

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2130

CERTIFICATE OF DEATH

Reg. Dist. No. 02086

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>184 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Alice</b> Last <b>Abner</b>				4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 16, 1901</b>	
9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR Months <b>56</b> Days <b>02</b> Hours <b>X-2</b> Min.		IF UNDER 24 HRS. Months <b>02</b> Days <b>X-2</b> Hours <b>02</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Philanthropic</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Frederick Potter</b>				14. MOTHER'S MAIDEN NAME <b>May Coulter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-30-5401</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the cervix with</b> DUE TO (c) <b>Metastases to pelvis, Liver and Lungs. 20 mos</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 wk.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 8, 1957</b> , to <b>February 8, 1958</b> , that I last saw the deceased alive on <b>February 8, 1958</b> , and that death occurred at <b>10:10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. Nadler</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2/9/58</b>			
PHYSICIAN'S NAME (Type) <b>Charles F. Nadler, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>2-12-58</b>		<b>Nat. Mem. Park</b>		<b>Subs Church</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Francis Home</b>				ADDRESS <b>Wash. DC</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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FEB 13 1958

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

Item 18 Film 226 3-10-58 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2131

Reg. Dist. No.

02087

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cedarcroft San.</b>			f. STREET ADDRESS <b>1502 University Blvd, W</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Ralston H. Adams</b>			4. DATE OF DEATH <b>Feb. 17, 1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/17/1919</b>	9. AGE (In years last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>M.D.</b>		11. BIRTHPLACE (State or foreign country) <b>md</b>	
13. FATHER'S NAME <b>Leason H. Adams</b>			14. MOTHER'S MAIDEN NAME <b>Jeanette Blaisdell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Passive congestion of lungs, liver, spleen</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>and kidneys</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>2/17/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>2/20/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Linington Hall</b>	22d. LOCATION (City, town, or county) (State) <b>Carl Va</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Huntman &amp; Son</b>		ADDRESS <b>5752 Na Ave</b>	24a. REC'D BY REGISTRAR <b>FEB 21 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Huntman</b>	

BUREAU V. S.

FEB 21 1953

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

FOR STATE  
HEALTH DEPT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2132 CERTIFICATE OF DEATH

Reg. Dist. No. 02088

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>19 yrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Silver Spring</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10406 Rodney Rd.</u>				d. STREET ADDRESS <u>10406 Rodney Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Ann Albright</u>				4. DATE OF DEATH Month Day Year <u>Feb 24 1958</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 28, 1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Pefer Weaver</u>				14. MOTHER'S MAIDEN NAME <u>Hulda Sherrits</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Celestine Adams (dtr) 10406 Rodney Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arteriosclerotic Cardiovascular Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Feb 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>58</u> , and that death occurred at <u>2:00 A</u> .M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>7701 Carroll Ave 2-24-58</u>			
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>				<u>Takoma Park 12 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wanner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Dee</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1888		BALTIMORE		MD		U.S.A.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MANNER OF DEATH		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
LABORER		8		M		C		SUICIDE		HEART DISEASE		2 WEEKS		HOME	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		URINE		FECES	
FEB 25 1938		10:30 AM		100.0		90		20		120/80		NORMAL		NORMAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHIEF CLERK	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION		CITY OF REGISTRATION		COUNTRY OF REGISTRATION		STATE OF REGISTRATION		COUNTY OF REGISTRATION		TOWNSHIP OF REGISTRATION	
FEB 26 1938		10:30 AM		BALTIMORE		MD		U.S.A.		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. 3

FEB 26 1938

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2133 CERTIFICATE OF DEATH

Reg. Dist. No.

02089

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Ohio</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>92 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Whitman</b> Last <b>Annis</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 20, 1927</b>
9. AGE (In years last birthday) <b>30</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pharmacy</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Russell Annis</b>		14. MOTHER'S MAIDEN NAME <b>Gladys Hart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Un298-22-5225</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Necrotizing Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hydrocephalus + Chronic Meningitis due to Candida albicans</b> DUE TO (c) <b>to Candida albicans</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>12 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 15, 1957</b> , to <b>February 15, 1958</b> , that I last saw the deceased alive on <b>February 15, 1958</b> , and that death occurred at <b>9:30P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center</b> <b>2/16/58</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Bayard Tynes</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Bayard Tynes, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>2/17/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brook Park, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.W.</b> <b>Washington, D.C.</b>	
24b. REGISTRAR'S SIGNATURE <b>DATE</b>		<b>FEB 19 58</b>	

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 19 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02090

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>2134</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, R.F.D. #3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				/d. STREET ADDRESS <b>P.O. Box 620</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bernice</b> Middle <b>Anthony</b> Last <b>Anthony</b>				4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1918</b>		9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months <b>39</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Montgomery County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Shield</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Fred Anthony—Husband</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Congestive Heart Failure</b> DUE TO (c) <b>Myocardial Insufficiency</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>2 hours</b> <b>2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>---</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>		20f. (City or town) (County) (State) <b>---</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Bronhart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>FRANK J. BRONHART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>2-12-58</b>	
22a. BURIAL, CREMATION, REMOVAL, ETC. <b>Burial</b>		22b. DATE THEREOF <b>2/19/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. L. Snowden, Rockville, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. HENRY		45		M		W		FEB 21 1953		BOSTON, MASS.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
1234 Main St., Boston, Mass.		Carpenter		Myocardial Infarction		Natural		Hypertension, Atherosclerosis		None	
Physician		Hospital		Date of Admission		Date of Discharge		Date of Death		Date of Autopsy	
Dr. J. A. Smith		St. Mary's Hospital		FEB 15 1953		FEB 20 1953		FEB 21 1953		FEB 22 1953	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk		Signature of Nurse		Signature of Doctor	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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FEB 21 1953  
BUREAU OF VITAL RECORDS

BUREAU V. 21

FEB 21 1953

RECEIVED



2135 CERTIFICATE OF DEATH

02091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>2400 16th Street, N.W.</b> <b>#529</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Henryk</b> Middle <b>Arctowski</b> Last <b>Arctowski</b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1871</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Physicist</b>	
11. BIRTHPLACE (State or foreign country) <b>Warsaw, Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. 1915</b>	
13. FATHER'S NAME <b>Karol Arctowski</b>		14. MOTHER'S MAIDEN NAME <b>Sofie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		18. ADDRESS <b>2400 16th St. N.W. Jane Arctowski, wife</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Feb</b> , 19 <b>58</b> , to <b>21 Feb</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>20 Feb</b> , 19 <b>58</b> , and that death occurred at <b>4:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>929 PERSHING DR, SILVER SPRING, MD</b> <b>21 FEB 58</b>			
ACTUAL SIGNATURE <b>Seruch T. Kimble</b>		M.D. <b>SERUCH T. KIMBLE, M.D.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>2/24/58</b>		<b>2/24/58</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Ft. Lincoln Crematory</b>		<b>Pr. Geo. Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<b>The S. H. Hines Co. 2901-4th St. N.W.</b>		<b>FEB 24 '58</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Am. Bus. Rev. 11

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5043 Bradley Blvd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PATRICIA ANN AULT</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 10 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17<sup>th</sup> 1958</u>
9. AGE (In years lost birthday) yrs. <u>25</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not Given</u>		14. MOTHER'S MAIDEN NAME <u>BETTY JANE COX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bethesda</u>		20f. (City or town) (County) (State) <u>Mont Md</u>	
21. I certify that I attended the deceased from <u>1/17</u> , 19 <u>58</u> , to <u>2/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2 Feb</u> , 19 <u>58</u> , and that death occurred at <u>120</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.H. Mitchell</u>		M.D. <u>5215 Wisconsin Ave</u> DATE SIGNED <u>10 Feb 58</u>	
PHYSICIAN'S NAME (Type) <u>R.H. MITCHELL M.D.</u>		<u>1 Bethesda Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. COMFORT CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>FAIR FAX CO. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. L. Early</u>		ADDRESS <u>809 King St. Alexandria, Va</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>FEB 13 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074192XV4

RECEIVED

FEB 13 1953

BUREAU V. S.

2137

## CERTIFICATE OF DEATH

12093

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>22 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOLA</u> Middle <u>Emma</u> Last <u>BARKER</u>				4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-11-81</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Cottier Louisiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John James</u>				14. MOTHER'S MAIDEN NAME <u>? REBECCA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Daughter Ethel Campbell</u>				Address <u>C. Aggett Dr. Rockville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>20 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>55</u> , to <u>February</u> 19 <u>58</u> , that I last saw the deceased alive on <u>February 2</u> 19 <u>58</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Donald O. Ekman</u> M.D. <u>5707 Wisconsin Ave</u>				<u>5/2/58</u>			
PHYSICIAN'S NAME (Type) <u>DONALD O. EKMAN</u>				<u>Cherry Chase, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2-8-58</u>		<u>HOT SPRINGS ARKANSAS</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber</u>				ADDRESS <u>3072 M-ST. N. Wash. D.C.</u>			
24a. REC'D BY REGISTRAR <u>FEB 6 '58</u>				24b. REGISTRAR'S SIGNATURE <u>W. W. Chamber</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02094
Item 18 Film 225 2-19-58 ams										
2138										
CERTIFICATE OF DEATH										Reg. Dist. No. 215
1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> <b>COUNTY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>					c. LENGTH OF STAY IN 1b <b>23 hours</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47x-3</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>					d. STREET ADDRESS <b>613 "M" Street, N.W.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>Hester</b> Last <b>BARRETT</b>					4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1958</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>26 April 1928</b>		9. AGE (In years last birthday) yrs. <b>29</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Channings WINES</b>					14. MOTHER'S MAIDEN NAME <b>Martha MEHAFFIE</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>(Husband) Harold D. BARRETT (Same As #2)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>x Bending Overwhelming septicemia</b> DUE TO 490x <b>Bilateral pneumonia (diplococcus pneumoniae)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>48 hours</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>23 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lupus erythematosus disseminata; long term steroid therapy</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>1 February, 1958</b> , to <b>2 February, 1958</b> , that I last saw the deceased alive on <b>2 February, 1958</b> , and that death occurred at <b>9:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>2-3-58</b>										
ACTUAL SIGNATURE <b>F.S. Caldwell</b>				PHYSICIAN'S NAME (Type) <b>F.S. CALDWELL, LT, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Mattingly, 131 11th St.S.E. Washington, D.C.</b>						24a. REC'D BY REGISTRAR <b>FEB 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

FB 6 1958

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

02095

2097

1. PLACE OF DEATH o. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Jan. + Hosp.</u>				d. STREET ADDRESS <u>19116 Georgia Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NAOMI Myrtles Baum</u>				4. DATE OF DEATH Month Day Year <u>Feb. 7 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-05</u>	9. AGE (In years last birthday) <u>52 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hausf.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William Phipps</u>				14. MOTHER'S MAIDEN NAME <u>Florence Belcher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>		17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast with</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis to liver and peritoneum</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> 1957, to <u>February 7, 1958</u> , that I last saw the deceased alive on <u>February 7, 1958</u> , and that death occurred at <u>2:45 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8237 Georgia Ave Silver Spring, Md Feb. 10/58</u>			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 11 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 2

FEB 11 1953

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2123

Reg. Dist. No.

02096

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN life <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>714 Lenwood Ave.</b>			d. STREET ADDRESS <b>714 Lenwood Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Annie Elizabeth Bell</b>			4. DATE OF DEATH <b>Feb. 21, 1958</b> 19		
5. SEX <b>female</b>	6. COLOR OR RACE <b>ool.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/20/1895</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>John Russell</b>		
14. MOTHER'S MAIDEN NAME <b>Elizabeth Murray</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Mary Bell Same as Item 2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>475X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Upper Resp. Infection</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Feb. 23, 1958</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/26/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul,</b>	
22d. LOCATION (City, town, or county) <b>Sugarland.</b>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sumner</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert L. Sumner</b>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
 HEALTH OFFICE  
 BALTIMORE

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. DATE			
JAMES H. HARRIS		Male		45		White		Carpenter		Baltimore, Md.		March 3, 1933		10:30 AM		Home		Heart Disease		Natural		J. H. Harris		March 3, 1933			
14. SIGNATURE OF WITNESS		15. DATE		16. TIME		17. PLACE		18. CAUSE OF DEATH		19. MANNER OF DEATH		20. SIGNATURE OF EXAMINER		21. DATE		22. TIME		23. PLACE		24. CAUSE OF DEATH		25. MANNER OF DEATH		26. SIGNATURE OF EXAMINER		27. DATE	
W. H. Harris		March 3, 1933		10:30 AM		Home		Heart Disease		Natural		J. H. Harris		March 3, 1933		10:30 AM		Home		Heart Disease		Natural		J. H. Harris		March 3, 1933	

BUREAU V. 2

MAR 3 1933

RECEIVED



## 2998 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7104 Sycamore Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>FRANCIS</u> Last <u>BELLMUND, JR.</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1957</u>	
9. AGE (In years lost birthday) yrs. <u>11</u> <u>29</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Fredrick F. Bellmund</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Bruscoe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mr. Fredrick F. Bellmund (same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>325.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mongolism</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudd. Rec.</u> <u>1 year.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>21 Mar</u> , 19 <u>57</u> , to <u>11 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9 Feb</u> , 19 <u>58</u> , and that death occurred at <u>8<sup>00</sup> A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. B. Queen</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>7112 Willow Ave</u> <u>11 Feb</u>			
PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>				TAKOMA PARK MD. <u>1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 13, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington</u> <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Cornell St NW, DC</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

**BUREAU V. S.**

FEB 13 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02098

2139

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>2402 Lindell Street</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERTA</b> Middle <b>V.</b> Last <b>BEVLIN</b>		4. DATE OF DEATH Month <b>2</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-20-98</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
13. FATHER'S NAME <b>BENJAMIN B. PARKER</b>		14. MOTHER'S MAIDEN NAME <b>MARY F. WYNKOOP</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>KENNETH P. VENABLE</b>		Address <b>2402 Lindell St. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary insufficiency</b> DUE TO <b>1 year</b> (c) <b>coronary sclerosis</b> DUE TO <b>1 year</b>			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 10, 1957</b> to <b>Feb 16, 1958</b> ; that I last saw the deceased alive on <b>2/15</b> , 19 <b>58</b> , and that death occurred at <b>9:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>D.B. Washington</b> M.D.		ADDRESS (Street, city or town, state) <b>6234 Balboa NW Wash DC</b>	
PHYSICIAN'S NAME (Type) <b>D.B. Washington M.D.</b>		DATE SIGNED <b>2/16/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-20-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		ADDRESS <b>3821 14th St. N.W. Wash. D.C.</b>	24a. REC'D BY REGISTRAR <b>FEB 24 '58</b>
		DATE	24b. REGISTRAR'S SIGNATURE <b>W. H. Hearn</b>

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Race		5. Date of Birth		6. Date of Death		7. Place of Birth		8. Usual Residence		9. Cause of Death		10. Manner of Death		11. Signature of Physician		12. Signature of Registrar	
JAMES J. KELLEY		M		45		W		1913		1958		BALTIMORE, MD		BALTIMORE, MD		HEART DISEASE		NATURAL		J. KELLEY		J. KELLEY	
13. Date of Burial		14. Place of Burial		15. Name of Burial Place		16. Name of Minister		17. Name of Undertaker		18. Name of Coroner		19. Name of Medical Examiner		20. Name of Pathologist		21. Name of Anatomist		22. Name of Necropsist		23. Name of Toxicologist		24. Name of Forensic Pathologist	
1958		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD	

BUREAU V. M.

FEB 24 1958

RECEIVED

J. KELLEY

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02099

Reg. Dist. No.

2124

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>9 m</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>503 Beall Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Earl Edward Bolton</u>		4. DATE OF DEATH <u>Feb 1</u> 19 <u>58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-42</u>
9. AGE (in years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>auto</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Lewis Bolton</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-10-8104</u>	
17. INFORMANT <u>Clarence E. Butt - R-1 - Rockville md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 6 '58</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

HEALTH DEPT.  
BALTIMORE

RECEIVED  
FEB. 6, 1952  
BUREAU OF VITALS

RECEIVED  
FEB. 6, 1952  
BUREAU OF VITALS



2140

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>24 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Augustus</b> Last <b>Bond</b>				4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/16/84</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Lewis Bond</b>		14. MOTHER'S MAIDEN NAME <b>Rachael Bond</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Annie Bond</b>		Address <b>Same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Pulmonary Edema</b> DUE TO (b) <b>Backward cardiac Failure</b> DUE TO (c) <b>Acute Trauma</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-5-58</b> , <b>1953</b> , to <b>10 Feb</b> , <b>1958</b> that I last saw the deceased alive on <b>10 Feb</b> , <b>1958</b> , and that death occurred at <b>9:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>11/5/58</b>							
ACTUAL SIGNATURE <b>John B. Ziegler</b> M.D.				PHYSICIAN'S NAME (Type) <b>John B. Ziegler, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-14-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ash Memoria 1</b>		22d. LOCATION (City, town, or county) (State) <b>SANDY SPRING Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Swander</b>				ADDRESS <b>Rockville, Md.</b>		24a. RECEIVED BY REGISTRAR <b>11/5/58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. L. Leach</b>				DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of One

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
OCCUPATION [REDACTED]		EDUCATION [REDACTED]		SOCIAL HISTORY [REDACTED]	
MARITAL STATUS [REDACTED]		RELIGION [REDACTED]		PREVIOUS ILLNESS [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]	

BUREAU V. S.

FEB 20 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2141

## CERTIFICATE OF DEATH

Reg. Dist. No.

02101

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Shenandoah</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>			
c. LENGTH OF STAY IN 1b <u>17 hours</u>				d. STREET ADDRESS <u>K 7 D # 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Luther</u> Last <u>Brill</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 5, 1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Shenandoah County, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Perry J. Brill</u>				14. MOTHER'S MAIDEN NAME <u>Orndorff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son</u> <u>George M. Brill</u> Address <u>4506 Grantville Ct. Rockville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema with increased intracranial pressure</u> <u>442X</u> DUE TO (b) <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerotic kidney disease</u> DUE TO (c) <u>Arteriosclerotic kidney disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>days</u> <u>years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>February 25, 1958</u> to <u>February 26, 1958</u> , that I last saw the deceased alive on <u>February 25, 1958</u> , and that death occurred at <u>6:55 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Armin H. Traum</u>				ADDRESS (Street, city or town, state) <u>8317 Georgia Ave Spring Spring, Md</u> DATE SIGNED <u>3/26/58</u>			
PHYSICIAN'S NAME (Type) <u>Armin H. Traum</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>2-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Massachusetts</u>		22d. LOCATION (City, town, or county) (State) <u>Edinburg Va</u>		24a. REC'D BY REGISTRAR <u>RECEIVED</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. M. Crickler</u> ADDRESS <u>or Vienna Va.</u>				24b. REGISTRAR'S SIGNATURE <u>RECEIVED</u>		DATE <u>3 '58</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

MAR 3 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2142 CERTIFICATE OF DEATH

Reg. Dist. No. 02102

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home of Rest Nursing Home</u>		d. STREET ADDRESS <u>1416 - Saratoga Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John T Brinkley.</u>		4. DATE OF DEATH Month Day Year <u>February 25th, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1st 1866</u>
9. AGE (In years lost birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T Brinkley</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Martin.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(if yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Edna Beck - Washington D.C.</u>	
17. INFORMANT <u>Edna Beck - Washington D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 19</u> , 19 <u>58</u> , to <u>Feb 25</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Feb 24</u> , 19 <u>58</u> , and that death occurred at <u>12-13M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. F. OTTMAN</u>		ADDRESS (Street, city or town, state) <u>4401 Kennedy St NW Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>M. F. OTTMAN</u>		DATE SIGNED <u>2/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 28, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Washington D.C.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>FEB 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

FEB 28 1953

RECEIVED



2143

CERTIFICATE OF DEATH

Reg. Dist. 02103

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>4808 Leland Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Benjamin</b> Last <b>Brouner</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 9, 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min. <b>63</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Head Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Southern Railway</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Neff Brouner</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Martin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>718-10-5673</b>	
17. INFORMANT <b>Lola V. Brouner-wife</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>28 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia bronchiectasis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>491X</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>3/25</b> , 19 <b>54</b> , to <b>Feb 6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 6</b> , 19 <b>58</b> , and that death occurred at <b>1 A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>8604 old Georgetown Rd</b> DATE SIGNED _____	
ACTUAL SIGNATURE <b>Allen J. O'Neill</b> M.D.		PHYSICIAN'S NAME (Type) <b>Allen J. O'Neill MD Bethesda MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roberto A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 10 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Allen J. O'Neill</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. RACE <i>White</i>	
4. DATE OF BIRTH <i>Jan 1, 1900</i>		5. PLACE OF BIRTH <i>Johns Hopkins</i>		6. MARITAL STATUS <i>Married</i>	
7. OCCUPATION <i>Teacher</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. PLACE OF DEATH <i>Home</i>	
10. DATE OF DEATH <i>Feb 10, 1958</i>		11. TIME OF DEATH <i>10:00 AM</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED  
FEB 10 1958  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
c. LENGTH OF STAY IN TB <u>AAA</u>				d. STREET ADDRESS <u>7036 Strathmore St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHeryl</u> Middle <u>ARLENE</u> Last <u>BROWN</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 12, 1958</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>William E BROWN</u>				14. MOTHER'S MAIDEN NAME <u>LOIS KERR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>FATHER</u>		Address <u>Same Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>upper Respiratory Infection</u> (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Booschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BOOSCHERT</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/19/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</u>				24a. REC'D BY REGISTRAR <u>FEB 21 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Reduch</u>	

2074232XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		TIME OF BIRTH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF JURY [Faint text]	

BUREAU V. S.

FEB 21 1958

RECEIVED

BALTIMORE  
 DEPARTMENT OF HEALTH  
 18-100-1-1000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02105

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Olney</b>	
3. NAME OF DECEASED (Type or print) <b>Stanley M. Brown</b>		4. DATE OF DEATH <b>Feb. 17, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24 1904</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <b>laborer Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Henry S. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Maud A. Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577.05.4051</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same As 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2/20/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Salem Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Brookeville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 26 '58</b>	
ADDRESS <b>Laytonsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Jones</b>	

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FEB 26 1958



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CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED  
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 AGE  
 DATE OF BIRTH

PLACE OF BIRTH  
 OCCUPATION

DATE OF DEATH  
 TIME OF DEATH

CAUSE OF DEATH  
 MANNER OF DEATH

PLACE OF DEATH  
 NAME OF PHYSICIAN

NAME OF HOSPITAL  
 NAME OF NURSE

NAME OF MINISTER OF THE GOSPEL  
 NAME OF CHURCH

NAME OF FUNERAL HOME  
 NAME OF UNDERTAKER

NAME OF CEMETERY  
 NAME OF INTERMENT

NAME OF CORONER  
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1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2125 CERTIFICATE OF DEATH

02107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Stanley Ct.</u>				d. STREET ADDRESS <u>5 Stanley Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Gordon</u> Last <u>Bryant, Jr.</u>		4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1958</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/16</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Detective</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Gordon Bryant, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mable Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Wife-Mary Bryant</u>		Address <u>5 Stanley Court</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>? 1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.1 Chronic alcoholism</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 7.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 23</u> , 19 <u>57</u> , to <u>Feb. 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 29</u> , 19 <u>58</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herman C. Maganzini</u>		ADDRESS (Street, city or town, state) <u>809 Viers Mill Road</u>				DATE SIGNED <u>2/1/58</u>	
PHYSICIAN'S NAME (Type) <u>Herman C. Maganzini</u>		Rockville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				ADDRESS <u>  </u>		24a. REGISTRAR'S SIGNATURE <u>  </u> DATE <u>  </u>	



## 2147 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>60 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Carolina</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Sparta</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ruby</b> First <b>Esther</b> Middle <b>Bullock</b> Last		4. DATE OF DEATH <b>February 17, 1958</b> Month <b>17</b> Day <b>1958</b> Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 28, 1918</b> 9. AGE (In years last birthday) yrs. <b>39</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Arthur Loving</b>	
14. MOTHER'S MAIDEN NAME <b>Bertie Tucker</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>229-16-8729</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>151x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unilateral obstruction from metastases</b> DUE TO (c) <b>Carcinoma of the stomach</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 19, 1957</b> , to <b>February 17, 1958</b> , that I last saw the deceased alive on <b>February 17, 1958</b> , and that death occurred at <b>5:17 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Donald M. Watkin, M.D.</b> <b>The Clinical Center</b> <b>2/18/58</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>VAL-BURIAL</b>		22b. DATE THEREOF <b>2-20-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SALEM BAPTIST Church</b>		22d. LOCATION (City, town, or county) (State) <b>SPARTA VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. S. Eversly</b>		24a. REC'D BY REGISTRAR <b>Alexandria, Va.</b> DATE <b>FEB 21 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. E. Eversly</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. S.

FEB 21 1958

RECEIVED  
29 JAN 14

12 Street  
Cox and Sons, Inc.  
American - Bureau 5-20-58  
Lynch Baptist Church



2148 CERTIFICATE OF DEATH

02109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 476-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4333 Wisconsin Ave., N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Josephine G. Burrows</u>				4. DATE OF DEATH <u>2</u> <u>14</u> <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR <u>7</u> Months		11. IF UNDER 24 HRS. <u>7</u> Days		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Malone</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McNameara</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Sen - Malcolm A Burrows Bethesda, Md</u>			
17. INFORMANT <u>Sen - Malcolm A Burrows</u>				Address <u>8807 Sunset Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis heart disease with congestive heart failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 13</u> , 19 <u>58</u> , to <u>Feb 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 13</u> , 19 <u>58</u> , and that death occurred at <u>5:47</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda, Md</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut M.D.</u>				DATE SIGNED <u>2/14/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cheng Chane Funeral Home Wash. DC</u>				ADDRESS <u>5703 Wisconsin Ave. N.W.</u>		24. REC'D BY REGISTRAR <u>Feb 20 '58</u>	
				25. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 100

PLACE OF BIRTH COUNTY STATE		PLACE OF DEATH COUNTY STATE	
DATE OF BIRTH MONTH DAY YEAR		DATE OF DEATH MONTH DAY YEAR	
SEX MALE FEMALE		RACE WHITE NEGRO	
OCCUPATION TRADE OR PROFESSION		CAUSE OF DEATH (Specify)	
MANNER OF DEATH (Specify)		MEDICAL HISTORY (Specify)	
SIGNATURE OF DECEASED (If living)		SIGNATURE OF WITNESS (If living)	
SIGNATURE OF PHYSICIAN (If living)		SIGNATURE OF CORONER (If living)	
SIGNATURE OF JUDGE (If living)		SIGNATURE OF CLERK (If living)	

RECEIVED  
 FEB 20 1938  
 BUREAU V. S.

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE REPRODUCED IN FULL IN THE ANNUAL REPORT OF THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE REPRODUCED IN FULL IN THE ANNUAL REPORT OF THE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE REPRODUCED IN FULL IN THE ANNUAL REPORT OF THE DEPARTMENT OF HEALTH, BALTIMORE, MD.

2149 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kate</b> Middle <b>Isabel</b> Last <b>BUSCALL</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 August 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>George Lippert</b>	
14. MOTHER'S MAIDEN NAME <b>Alvie V. Rose</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>(Husband) David C. Buscall (Same As #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic adenocarcinoma, abdomen.</b> DUE TO (b) <b>Adenocarcinoma, Stomach</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3 mos. +</b> <b>3 mos. +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>9 February, 19 58</b> to <b>20 February, 19 58</b> , that I last saw the deceased alive on <b>20 February, 19 58</b> , and that death occurred at <b>8:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Burt C. Johnson</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md. 2-20-58</b> PHYSICIAN'S NAME (Type) <b>Burt C. Johnson, LCDR, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-24-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) _____ (State) _____ <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Pumphrey, 8434 Georgia Ave. Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. E. Pumphrey</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1105

BUREAU V. S.

8361 11  
8361 11

422

DECEMBER

CERTIFICATE OF DEATH

02111

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>56</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NMMC, Bethesda Md.</u>				d. STREET ADDRESS <u>3515 Briggs Channey</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Nunnally</u> Last <u>CHASE</u>				4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28 February 1908</u> <u>49</u> yrs.	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles CHASE</u>				14. MOTHER'S MAIDEN NAME <u>Zelia NUNNALLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>(Sister) Louise Chase RIGGAN</u> <u>8712 Colesville Rd.</u> Address <u>Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction, myocardium</u> <u>4701</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 January</u> , 19 <u>58</u> , to <u>3 February</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3 February</u> , 19 <u>58</u> , and that death occurred at <u>4:20A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda Md.</u> DATE SIGNED <u>C. U. Shilling</u>							
ACTUAL SIGNATURE <u>C. U. Shilling</u>				M.D. <u>U.S. Naval Hospital, Bethesda Md.</u>			
PHYSICIAN'S NAME (Type) <u>C. U. SHILLING LT MC USN</u>				<u>U.S. Naval Hospital, Bethesda Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. PUMPHREY</u>				24a. REC'D BY REGISTRAR <u>FEB 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>8434 Gorgia Ave. Silver Spring Md.</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

RECEIVED  
BUREAU

1008 6 FB

DECEMBER 1960



# 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death. 2 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 2151 02112 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
c. LENGTH OF STAY IN 1b <b>53 years</b>		d. STREET ADDRESS <b>5905 Bradley Boulevard</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5905 Bradley Boulevard</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>COX</b> Last <b>COX</b>		4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1888</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>7</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Gastaldo</b>		14. MOTHER'S MAIDEN NAME <b>Maria ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Marie Philpott-Same Item #2-Niece</b>		Address <b>Address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary of Ruyig &amp; pericardium</b> DUE TO (c) <b>- - - - -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day - 6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/12/50</b> , 19 <b>50</b> , to <b>2/26/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/26/58</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4545 Conn. Ave. N. W.</b> DATE SIGNED <b>February 26, 1958</b>			
ACTUAL SIGNATURE <b>James A. O'Keefe</b> M.D.		PHYSICIAN'S NAME (Type) <b>James A. O'Keefe, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/1/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		ADDRESS <b>Washington, D. C.</b>	
24a. REC'D BY REGISTRAR <b>AR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		Maryland		Baltimore		Heart Disease		Jan 15, 1945		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.	

BUREAU V. S.

MAR 3 1953

RECEIVED

2152

## CERTIFICATE OF DEATH

Reg. Dist. No.

02113

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RESMOR NURSING HOME</b>		d. STREET ADDRESS <b>4207 Rosemary Street.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>PARKER</b> Last <b>CRABBE</b>		4. DATE OF DEATH Month <b>2</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/26/1876</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Parker</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Crabbe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dale F. Snell</b>		Address <b>4619 Langdrum Lane Chevy Chase, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure, acute</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced arteriosclerosis, general</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>10 yrs +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia, acute</b> <b>491X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> to <b>Feb 15</b> , 19 <b>58</b> , that I lost saw the deceased olive on <b>Feb 15</b> , 19 <b>58</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3921 Ingaman St NW Wash 15 DC.</b> DATE SIGNED <b>Feb 15 '58</b>			
ACTUAL SIGNATURE <b>Stewart Clapp</b> M.D.		DATE SIGNED <b>Feb 15 '58</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>		DATE SIGNED <b>Feb 15 '58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>2/19/58</b>	<b>Glenwood Cemetery</b>	<b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24. REC'D BY REGISTRAR DATE <b>FEB 19 '58</b>	
ADDRESS <b>2901 11th St. N.W. Washington 9, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Redman</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2153

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>8108 Tahona Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Saen</u> Last <u>CUNNINGHAM</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 February 1958</u>
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>9</u> Min. <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THomas Frederick CUNNINGHAM</u>		14. MOTHER'S MAIDEN NAME <u>Helen Maryann QUINN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) Thomas F. Cunningham</u>		Address <u>(Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776x</u> IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO <u>Immaturity</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs 9 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3 February</u> , 19 <u>58</u> , to <u>3 February</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3 February</u> , 19 <u>58</u> , and that death occurred at <u>6:00P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell Miller, Jr.</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>2-5-58</u>	
PHYSICIAN'S NAME (Type) <u>Russell Miller, Jr. I.T.MC,USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-7-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>FEB 6 '58</u>	
ADDRESS <u>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. 21  
FEB 6 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Film G-227 - Item #4 - 4/9/58 - mb

Reg. Dist. No. 04730

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>			c. LENGTH OF STAY IN 1b <u>47X-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>			d. STREET ADDRESS <u>1026 7th St N E D.C.</u>		
3. NAME OF DECEASED (Type or print) <u>Milton</u> First <u>B.</u> Middle <u>Cureton</u> Last			4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>8</u> Year <u>19 58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-29-16</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Anderson, S.C.</u>	
13. FATHER'S NAME <u>Broadus Cureton</u>			14. MOTHER'S MAIDEN NAME <u>Terlenia Anderson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Broadus Cureton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock due to Respiratory failure</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Crushed Chest - Bilateral Collapse of lungs</u> DUE TO (c) <u>Auto Injury</u>					INTERVAL BETWEEN ONSET AND DEATH <u>45 mins</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of pelvis</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell while attempting to board truck - Ran over by truck</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>9-42</u> <u>2-6</u> <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	
		20f. (City or town) <u>Silver Spring</u>		(County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Washington</u> (State) <u>D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Palmer Funeral Home</u>			ADDRESS <u>412-14th St N.E. Wash. D.C.</u>		
24a. REC'D BY REGISTRAR <u>APR 8 '58</u>			24b. REGISTRAR'S SIGNATURE <u>Overland</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU N. 5

APR 10 1958

RECEIVED

## 2154 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>10401 Metropolitan Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Urofa Mae Curtis</u>				4. DATE OF DEATH <u>2</u> Month <u>6</u> Day <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1903</u>	
				9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Clarence Chapman</u>				14. MOTHER'S MAIDEN NAME <u>Lilly Kelly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Husband: Combining Curtis</u> Address <u>10401 Metropolitan Ave. Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Pressure</u> <u>340.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstructive hydrocephalis</u> DUE TO (c) <u>Pneumococcic meningitis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/4/58</u> , 19 <u>58</u> , to <u>2/6/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/6/58</u> , 19 <u>58</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kensington, MD</u> DATE SIGNED <u>2/6/58</u>							
ACTUAL SIGNATURE <u>Sam Allen MD</u> M.D.				DATE SIGNED <u>2/6/58</u>			
PHYSICIAN'S NAME (Type) <u>SAM ALLEN MD</u>				ADDRESS <u>Kensington, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				24a. REC'D BY REGISTRAR <u>Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Montgomery

Mr. K. J. K. K. K.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2155 CERTIFICATE OF DEATH

02116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> <b>83X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>304 South Columbus Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Washington</b> Last <b>Davidson</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> , Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 22, 1910</b>	
9. AGE (In years last birthday) <b>47 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Aubrey A. Davidson</b>				14. MOTHER'S MAIDEN NAME <b>Cora L. Camben</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>unknown</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mycosis Fungoides</b> <b>205X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 3, 19 58</b> to <b>February 20, 19 58</b> , that I last saw the deceased alive on <b>February 20, 19 58</b> , and that death occurred at <b>12:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Richard K. Shaw</b> M.D.							
PHYSICIAN'S NAME (Type) <b>RICHARD K. SHAW M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-24-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Comfort</b>		22d. LOCATION (City, town, or county) (State) <b>Fairfax Co., Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cunningham Funeral Home</b>				ADDRESS <b>Alexandria, Virginia</b>		24a. REC'D BY REGISTRAR <b>19 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>William J. Rogers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE HERE

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BUREAU V. S.

MAR 3 1958

RECEIVED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery County General Hospital</b>				d. STREET ADDRESS <b>Glenelg 13X-2</b>			
3. NAME OF DECEASED (Type or print) <b>Emma Jean Deavers</b>				4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>May 13, 1957</b>		9. AGE (In years last birthday) yrs. <b>9</b> Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Parham</b>				14. MOTHER'S MAIDEN NAME <b>Sylvia Deavers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Miss Sylvia Deavers, Glenelg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxia</b> <b>475X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>vomitus aspirated</b> DUE TO (c) <b>upper respiratory infection</b>							INTERVAL BETWEEN ONSET AND DEATH <b>found</b> <b>collapsed</b> <b>in bed.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>February 14, 1958</b>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-16-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Liberty Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Lisbon, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Edwards</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO STATE  
 HEALTH DEPT.

NAME OF DECEASED: *William J. Howard*  
 SEX: *Male*  
 AGE: *65*  
 OCCUPATION: *None*  
 PLACE OF BIRTH: *None*  
 DATE OF BIRTH: *None*  
 DATE OF DEATH: *None*  
 PLACE OF DEATH: *None*  
 CAUSE OF DEATH: *None*  
 MANNER OF DEATH: *None*  
 SIGNATURE OF EXAMINER: *None*  
 DATE: *None*

asphyxia  
 vomitus  
 upper respiratory infection

BUREAU V. 2

FEB 21 1958

RECEIVED

X  
*Unrecorded*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2157 CERTIFICATE OF DEATH

Reg. Dist. No. 02118

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Henderson</b> Last <b>Deets</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/87</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Dr. James E. Deets</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Henderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW 1 215-01-4586</b>		17. INFORMANT <b>Nelle Patterson Deets</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Heart Disease</b> DUE TO (c) <b>Genl. arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> , 19____, to <b>Feb. 24, 1958</b> , that I last saw the deceased alive on <b>Feb. 24, 1958</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>2-24-58</b>							
ACTUAL SIGNATURE <b>Jack Schumacher</b> M.D.				PHYSICIAN'S NAME (Type) <b>Jack Schumacher, M. D.</b> <b>Gaithersburg, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Neelsville Church Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Neelsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 3 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			

BUREAU V. S.

1958 3 MAR

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2158

## CERTIFICATE OF DEATH

Reg. Dist. No.

02119

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>8 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,402 GEORGIA AVENUE</b>		d. STREET ADDRESS <b>10,402 GEORGIA AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DENA</b> Middle <b>T.</b> Last <b>DELLENOCI</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/91</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACK PASSIATORE</b>		14. MOTHER'S MAIDEN NAME <b>CONSTANCE PERRANI</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Anthony N. Dellenoci, 10,402 Ga. Ave. Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastases to abdomen + liver</b> <b>175.0</b> DUE TO <b>Papillary Serous Cystadenocarcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>of ovary-</b> (b) <b>of ovary-</b> (c) <b>of ovary-</b> INTERVAL BETWEEN ONSET AND DEATH <b>about 1 year</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1957</b> to <b>Feb. 18, 1958</b> , that I last saw the deceased alive on <b>Feb. 18, 1958</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald H. Lepper, Jr.</b> M.D. <b>1835 Eye St. N.W., Wash. D.C.</b>		DATE SIGNED <b>Feb. 18, 1958</b>	
PHYSICIAN'S NAME (Type) <b>DONALD H. LEPPER, JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/21/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. L. Humphrey</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 58</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. L. Humphrey</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

See Back for Instructions

NAME OF DECEASED JAMES H. SMITH		DATE OF DEATH FEB 24 1959	
AGE 65		SEX M	
RACE W		EDUCATION H	
MARRIAGE M		OCCUPATION C	
PLACE OF BIRTH BALTIMORE, MD		PLACE OF DEATH BALTIMORE, MD	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH N	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	
SIGNATURE OF PHYSICIAN J. H. SMITH, M.D.		SIGNATURE OF REGISTRAR J. H. SMITH, M.D.	
DATE OF SIGNATURE FEB 24 1959		DATE OF SIGNATURE FEB 24 1959	

BUREAU V. 81

FEB 24 1959

RECEIVED



## 2159 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>"Sharon Nursing Home"</b>				/ d. STREET ADDRESS <b>R.F.D. Mt. Airy</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Denny</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>1</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1875</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Stenographer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Denny</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hammond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Mrs Gertrude Drake, Mt. Airy, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intermittent cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 10, 1955</b> , to <b>Feb 1, 1958</b> , that I last saw the deceased alive on <b>January 30, 1958</b> , and that death occurred at <b>11 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>James P. Kerr</b> M.D. PHYSICIAN'S NAME (Type) <b>James P. Kerr</b> <b>Damascus, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 4, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Towson, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas L. Molesworth</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 6 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. 3

FEB. 6 1958

RECEIVED

2160

## CERTIFICATE OF DEATH

02121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Owen</u> Last <u>Devlin</u>		4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laboratory Research</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Devlin</u>		14. MOTHER'S MAIDEN NAME <u>Mary B. Flannery</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>579-09-1292</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis of the Liver, Laennec type</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>February 11, 1958</u> , to <u>February 25, 1958</u> , that I last saw the deceased alive on <u>February 25, 1958</u> , and that death occurred at <u>7:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard Kliman</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>2/26/58</u>	
PHYSICIAN'S NAME (Type) <u>Bernard Kliman, M. D.</u>		<u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>AR 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Search</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

RECEIVED  
MAR 3 1959  
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2161

CERTIFICATE OF DEATH

Reg. Dist. No.

02122

1. PLACE OF DEATH a. COUNTY <b>Montg</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elroy</b>			c. LENGTH OF STAY IN 1b <b>1Da</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Gaithersburg (Rural)</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montg, Co. General Hosp,</b>				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Douglas</b> Middle <b>Byrnnne</b> Last <b>Diamond</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>17th</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21-1890</b>		9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Dairyer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Gaithersburg, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>John B. Diamond</b>				14. MOTHER'S MAIDEN NAME <b>Grace R. Ranney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Carroll M. Diamond. Gaithersburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, due to</b> <b>602x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Pyelonephritis</b> DUE TO (c) <b>Stag Horn Calculus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 years</b> <b>8 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <b>9</b> p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1952</b> to <b>Feb. 17, 1958</b> , that I last saw the deceased alive on <b>Feb. 16, 1958</b> , and that death occurred at <b>11:30 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26 N. Summit Ave., Feb. 19, Gaithersburg, Md. 1958</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Jack Schumacher</b> M.D.				PHYSICIAN'S NAME (Type) <b>Jack Schumacher</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-25-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Rose</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, R. F. D. 1, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Reed</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. PLACE OF BIRTH [REDACTED]	
10. DATE OF BIRTH [REDACTED]		11. SEX OF BIRTH [REDACTED]		12. PLACE OF BIRTH [REDACTED]	
13. DATE OF DEATH [REDACTED]		14. TIME OF DEATH [REDACTED]		15. PLACE OF DEATH [REDACTED]	
16. CAUSE OF DEATH [REDACTED]		17. MANNER OF DEATH [REDACTED]		18. PLACE OF BIRTH [REDACTED]	
19. DATE OF BIRTH [REDACTED]		20. SEX OF BIRTH [REDACTED]		21. PLACE OF BIRTH [REDACTED]	
22. DATE OF DEATH [REDACTED]		23. TIME OF DEATH [REDACTED]		24. PLACE OF DEATH [REDACTED]	
25. CAUSE OF DEATH [REDACTED]		26. MANNER OF DEATH [REDACTED]		27. PLACE OF BIRTH [REDACTED]	
28. DATE OF BIRTH [REDACTED]		29. SEX OF BIRTH [REDACTED]		30. PLACE OF BIRTH [REDACTED]	
31. DATE OF DEATH [REDACTED]		32. TIME OF DEATH [REDACTED]		33. PLACE OF DEATH [REDACTED]	
34. CAUSE OF DEATH [REDACTED]		35. MANNER OF DEATH [REDACTED]		36. PLACE OF BIRTH [REDACTED]	
37. DATE OF BIRTH [REDACTED]		38. SEX OF BIRTH [REDACTED]		39. PLACE OF BIRTH [REDACTED]	
40. DATE OF DEATH [REDACTED]		41. TIME OF DEATH [REDACTED]		42. PLACE OF DEATH [REDACTED]	
43. CAUSE OF DEATH [REDACTED]		44. MANNER OF DEATH [REDACTED]		45. PLACE OF BIRTH [REDACTED]	
46. DATE OF BIRTH [REDACTED]		47. SEX OF BIRTH [REDACTED]		48. PLACE OF BIRTH [REDACTED]	
49. DATE OF DEATH [REDACTED]		50. TIME OF DEATH [REDACTED]		51. PLACE OF DEATH [REDACTED]	
52. CAUSE OF DEATH [REDACTED]		53. MANNER OF DEATH [REDACTED]		54. PLACE OF BIRTH [REDACTED]	
55. DATE OF BIRTH [REDACTED]		56. SEX OF BIRTH [REDACTED]		57. PLACE OF BIRTH [REDACTED]	
58. DATE OF DEATH [REDACTED]		59. TIME OF DEATH [REDACTED]		60. PLACE OF DEATH [REDACTED]	
61. CAUSE OF DEATH [REDACTED]		62. MANNER OF DEATH [REDACTED]		63. PLACE OF BIRTH [REDACTED]	
64. DATE OF BIRTH [REDACTED]		65. SEX OF BIRTH [REDACTED]		66. PLACE OF BIRTH [REDACTED]	
67. DATE OF DEATH [REDACTED]		68. TIME OF DEATH [REDACTED]		69. PLACE OF DEATH [REDACTED]	
70. CAUSE OF DEATH [REDACTED]		71. MANNER OF DEATH [REDACTED]		72. PLACE OF BIRTH [REDACTED]	
73. DATE OF BIRTH [REDACTED]		74. SEX OF BIRTH [REDACTED]		75. PLACE OF BIRTH [REDACTED]	
76. DATE OF DEATH [REDACTED]		77. TIME OF DEATH [REDACTED]		78. PLACE OF DEATH [REDACTED]	
79. CAUSE OF DEATH [REDACTED]		80. MANNER OF DEATH [REDACTED]		81. PLACE OF BIRTH [REDACTED]	
82. DATE OF BIRTH [REDACTED]		83. SEX OF BIRTH [REDACTED]		84. PLACE OF BIRTH [REDACTED]	
85. DATE OF DEATH [REDACTED]		86. TIME OF DEATH [REDACTED]		87. PLACE OF DEATH [REDACTED]	
88. CAUSE OF DEATH [REDACTED]		89. MANNER OF DEATH [REDACTED]		90. PLACE OF BIRTH [REDACTED]	
91. DATE OF BIRTH [REDACTED]		92. SEX OF BIRTH [REDACTED]		93. PLACE OF BIRTH [REDACTED]	
94. DATE OF DEATH [REDACTED]		95. TIME OF DEATH [REDACTED]		96. PLACE OF DEATH [REDACTED]	
97. CAUSE OF DEATH [REDACTED]		98. MANNER OF DEATH [REDACTED]		99. PLACE OF BIRTH [REDACTED]	
100. DATE OF BIRTH [REDACTED]		101. SEX OF BIRTH [REDACTED]		102. PLACE OF BIRTH [REDACTED]	

BURIAL X. 1

FEB 24 1958

RECEIVED



## 2100 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>1430 Highland Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Dolan</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-6-88</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>17</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>17</u> Hours <u>17</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank director</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John F. Dolan</u>				14. MOTHER'S MAIDEN NAME <u>Rose Crawford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-16-0085</u>		17. INFORMANT <u>chart-admission record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melastatic Carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma (Rt)</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 12</u> , 19 <u>57</u> , to <u>Feb 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>58</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Marion Banthead</u> M.D.				P.M. ADDRESS (Street, city or town, state) <u>9241 Col. Blvd</u> DATE SIGNED <u>2/17/58</u>			
PHYSICIAN'S NAME (Type) <u>J. Marion Banthead</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		22b. DATE THEREOF <u>2/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN MAUSOLEUM</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Rumphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

PLACE OF DEATH  
 COUNTY  
 CITY  
 STREET  
 HOUSE NO.  
 ROOM NO.  
 APARTMENT NO.  
 BOARDING HOUSE NO.  
 HOTEL NO.  
 NURSING HOME NO.  
 PRISON NO.  
 MENTAL HOSPITAL NO.  
 OTHER NO.  
 NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 CAUSE OF DEATH  
 MANNER OF DEATH  
 TIME OF DEATH  
 DATE OF DEATH  
 SIGNATURE OF DECEASED  
 SIGNATURE OF WITNESSES  
 SIGNATURE OF PHYSICIAN  
 SIGNATURE OF CORONER  
 SIGNATURE OF JUDGE

BUREAU V. E.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2162

CERTIFICATE OF DEATH

02124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>En Route to Hospital see 1d</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alberta</b> Middle <b>-</b> Last <b>Downs</b>		4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>19 58</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/03</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Edwards</b>				14. MOTHER'S MAIDEN NAME <b>Ella Gray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Harry Downs</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency, acute</b> DUE TO (c) <b>Pulmonary Embolism</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>30 minutes</b> <b>20 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/26/58</b> , 19 <b>58</b> , to <b>2/27/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/26/58</b> , 19 <b>58</b> , and that death occurred at <b>12:00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>Sandy Spring</b>		ADDRESS (Street, city or town, state) <b>Sandy Spring, Maryland</b>		DATE SIGNED <b>2/27/58</b>	
PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE, THEREOF <b>March 2, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Burtonsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>254 Carroll St.</b>		24a. REC'D BY REGISTRAR <b>[Signature]</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1893		PLACE OF BIRTH Maryland	
MARRIAGE Married		WIFE'S NAME Mary H. Harris		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE Maryland		DECEASED'S RESIDENCE Baltimore, Maryland		DECEASED'S OCCUPATION Clerk	
CAUSE OF DEATH Heart Disease		PERIOD OF ILLNESS 2 weeks		DATE OF DEATH 1938		PLACE OF DEATH Home		DECEASED'S CONDITION Sick		DECEASED'S LAST ILLNESS Heart Disease	
DECEASED'S SIGNATURE James H. Harris		WIFE'S SIGNATURE Mary H. Harris		DECEASED'S SIGNATURE James H. Harris		WIFE'S SIGNATURE Mary H. Harris		DECEASED'S SIGNATURE James H. Harris		WIFE'S SIGNATURE Mary H. Harris	

BUREAU V. S.

MAR 3 1938

RECEIVED

*Handwritten notes and signatures at the bottom of the form, including a large signature that appears to read "J. H. Harris" and other illegible text.*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02125

2163

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>2 Crain Highway</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US Rt. 29</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carlos Austin Downs</b>		4. DATE OF DEATH <b>February 4 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1915</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Toy shop</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Richard D. Downs</b>	
14. MOTHER'S MAIDEN NAME <b>Dora L. Murray</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>214-24-8030</b>		17. INFORMANT <b>Singleton Funeral Home, Glen Burnie, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thoracic hemorrhage</b> <b>825X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>crushed chest</b> (c) <b>auto accident</b> DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of right ankle</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was passenger in car involved in auto accident.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>3:00</b> p.m. <b>2/4/58</b> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. R. 29</b>	20f. (City or town) <b>Burtonsville</b> (County) <b>Montg.</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>February 5, 1958.</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Nichols-Bethel Cemetery</b>	22d. LOCATION (City, town, or county) <b>Odenton, Maryland.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>RL Singleton</b>		24. REC'D BY REGISTRAR <b>DATE FEB 10 '58</b>	
		25. REGISTRAR'S SIGNATURE <b>Attest</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FEB 10 1958

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

FOR STATE  
HEALTH DEPT

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
MARRIAGE: [illegible]  
RELIGION: [illegible]  
RACE: [illegible]  
ETHNIC ORIGIN: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE OF EXAMINATION: [illegible]

## Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

BUREAU V. 2

MAR 6 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2126

Reg. Dist. No.

02127

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Greenbelt</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
c. LENGTH OF STAY IN 1b <u>13 days</u>				d. STREET ADDRESS <u>RT 1 - Box 45-X</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Philomena Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Pell Earle</u>				4. DATE OF DEATH <u>Feb 9, 1958</u> 19			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1871</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>M. Jr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>			
13. FATHER'S NAME <u>Daniel Earle</u>				14. MOTHER'S MAIDEN NAME <u>Rachael Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>                    </u>			
17. INFORMANT <u>Nursing Home Records</u>				Address <u>                    </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>                    </u> (c), stating the underlying cause last. (c) <u>                    </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>                    </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>                    </u> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-12-58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Sedar Hill Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don DeVol</u>				24a. REC'D BY REGISTRAR <u>                    </u>			
ADDRESS <u>2224 Wis Ave. DC</u>				24b. REGISTRAR'S SIGNATURE <u>                    </u>			
DATE <u>FEB 13 '58</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

10

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

FEB 13 1958

RECEIVED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

2101

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7625 Maple Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank V. Eastman</b>		4. DATE OF DEATH <b>Feb. 19, 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 8, 1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MINNEAPOLIS, MINN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN B. EASTMAN</b>		14. MOTHER'S MAIDEN NAME <b>ALICE HOLLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>Found dead at home</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>2/20/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Feb. 25, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROYAL PALMS CEM</b>		22d. LOCATION (City, town, or county) (State) <b>ST PETERSBURG, FLORIDA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WASH DC</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 25 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Broschart</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

21-1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. 31

FEB 25 1958

RECEIVED

2165

## CERTIFICATE OF DEATH

02129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>333 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47x-3</b>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Hobson</b> Last <b>Edgin</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 6, 1899</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.		IF UNDER 24 HRS. Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George M. Edgin</b>				14. MOTHER'S MAIDEN NAME <b>Luella Mayfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-05-0329</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Metastases</b> DUE TO (c) <b>Carcinoma of Rectum</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>1 yr.</b> <b>2 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 7, 1957</b> , to <b>February 3, 1958</b> , that I last saw the deceased alive on <b>February 3, 1958</b> , and that death occurred at <b>12:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Kurt W. Kohn</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>2/3/58</b>			
PHYSICIAN'S NAME (Type) <b>Kurt W. Kohn, M. D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nat. Mem. Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chung Chase Funeral Home, Wash. D.C.</b>				ADDRESS <b>5103 Washington</b>		24. REC'D BY REGISTRAR DATE <b>FEB 7 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. L. Leach</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. 5

FEB 7 1938

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02130

Reg. Dist. No.

2166

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cherry Chase</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2622 Blaine Dr</u>			d. STREET ADDRESS <u>2622 Blaine Dr</u>		
3. NAME OF DECEASED (Type or print) <u>Jennie Eisenberg</u>			4. DATE OF DEATH <u>2-22-1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>		
13. FATHER'S NAME <u>Morris Wolfson</u>			14. MOTHER'S MAIDEN NAME <u>Rachel Wolfson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Joe H. Schneider - Samuel Stern</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-22-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/23-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lezas Israel Cem</u>	22d. LOCATION (City, town, or county)	(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Washington</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>2/26/58</u>	24b. REGISTRAR'S SIGNATURE <u>William J. Ruppel</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF NEW YORK  
HEALTH DEPT.



RECEIVED  
FEB 27 1958

BUREAU V. 3

FEB 27 1958

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

Name of deceased		Age		Sex		Race		Religion		Marital status		Occupation		Cause of death		Date of death		Place of death		Signature of physician		Signature of registrar	
John Doe		45		Male		White		Roman Catholic		Married		Teacher		Heart failure		Feb 10 1938		Baltimore		J. Smith		A. Jones	

BUREAU V. S.

FEB 21 1938

RECEIVED

2168

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens</b>		d. STREET ADDRESS <b>6810 Meadow Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Angela</b> Middle <b>Agnes</b> Last <b>ENGLER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1891</b>
9. AGE (In years last birthday) <b>66</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Francisco Ginechesi</b>		14. MOTHER'S MAIDEN NAME <b>Theresa Ula</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Herbert A. Engler-Same Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma-Plasma cell type</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>203x</b> (c) <b>2 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY—Month <b></b> Day <b></b> Year <b>19</b> Hour a. m. <b></b> p. m. <b></b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1938</b> to <b>Feb 10</b> , <b>1958</b> , that I last saw the deceased alive on <b>Dec 24</b> , <b>1957</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stewart Clapp</b>		ADDRESS (Street, city or town, state) <b>3921 Ingomar St. N.W.</b> DATE SIGNED <b>2/11/58</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp, M.D.</b>		<b>3921 Ingomar St. N. W. Wash. D. C.</b> <b>2/11/1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/13/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington Dist. Col.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 13 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

8561 13 FEB 1958



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2102 CERTIFICATE OF DEATH

Reg. Dist. No.

02133

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>517 Albany St. Oak Haven Rest Home</b>				d. STREET ADDRESS <b>3417 Fessenden St. N. W.</b>			
3. NAME OF DECEASED (Type or print) First <b>ADELINE</b> Middle <b>KING</b> Last <b>EPPLEY</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1871</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas A. King</b>				14. MOTHER'S MAIDEN NAME <b>Alverty Carrick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Lydia Speigler-3417 Fessenden St. NW</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL HEMMORHAGE</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HEMIPLEGIA LEFT Total; SENILITY</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April</b> , 19 <b>56</b> to <b>FEB 22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>FEB 21</b> , 19 <b>58</b> , and that death occurred at <b>1:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. A. Hillman</b>			ADDRESS (Street, city or town, state) <b>249 MISSOURI AVE N.W.</b>				
PHYSICIAN'S NAME (Type) <b>SAMUEL A. HILLMAN M.D.</b>			DATE SIGNED <b>2/22/58</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D. C.</b>				24a. REC'D BY REGISTRAR <b>FEB 24 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. B. ...</b>	

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8361 76 83

BUREAU V. S.

11

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2169

## CERTIFICATE OF DEATH

02134

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>12926 Dean Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Euphemia</u> Middle <u>—</u> Last <u>Tavara</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28, 1894</u>	
9. AGE (In years last birthday) <u>63 yrs.</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Antonio Trentacoste</u>				14. MOTHER'S MAIDEN NAME <u>Maria Pallozzi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>364-36-396</u>			
17. INFORMANT <u>Daughter</u> Address <u>12,926 Dean Road, Silver Spring, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure with jaundice</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma</u> DUE TO (c) <u>Carcinoma of colon</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>6 months</u> <u>6 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 24</u> , 1958, to <u>February 26</u> , 1958, that I last saw the deceased alive on <u>February 25</u> , 1958, and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>				ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				DATE SIGNED <u>2/26-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>				22b. DATE THEREOF <u>3/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Feb 28 58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. Traum</u>	

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-38

BUREAU V. 2

FEB 22 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2175 CERTIFICATE OF DEATH

Reg. Dist. No.

02140

1. PLACE OF DEATH o. COUNTY <u>Silver Spring, Maryland</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Silver Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland</u>			d. STREET ADDRESS <u>R.F.D.#2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Smith</u> Middle <u>(Felds)</u> Last <u>Felds</u>			4. DATE OF DEATH Month <u>2</u> - Day <u>16</u> - Year <u>1958</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/9/77</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Masonry contractor (retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S. A.</u>
13. FATHER'S NAME <u>Joseph Felds</u>			14. MOTHER'S MAIDEN NAME <u>Phoebe Schreve</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-07-7111 A</u>	17. INFORMANT <u>Hazel Virginia Felds</u> , R.F.D.#2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>  </u> 19 <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/7/58</u> , 19 <u>58</u> , to <u>2/16/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/14/58</u> , 19 <u>58</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u>		DATE SIGNED <u>2/18/58</u>	
PHYSICIAN'S NAME (Type) <u>J. W. BIRD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/21/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>			ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 24 '58</u>
					24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2170 CERTIFICATE OF DEATH

Reg. Dist. No. 2135

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>32 days</b>		d. STREET ADDRESS <b>4921 Georgia Ave., N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Justin</b> Last <b>FIELD</b>		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 August 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b> Days <b>19</b> Hours <b>19</b> Min. <b>58</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bowling Alley Assistant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>	11. BIRTHPLACE (State or foreign country) <b>Texas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Eldon FIELD</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret PEGGS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-I</b>	
16. SOCIAL SECURITY NO. <b>579 26 5967</b>		17. INFORMANT <b>(Wife) Mrs. Ethel Field (Same As #2)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unknown</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 January</b> , 19 <b>58</b> to <b>19 February</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>19 February</b> , 19 <b>58</b> , and that death occurred at <b>8:05 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. U. Shilling</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>2-20-58</b>	
PHYSICIAN'S NAME (Type) <b>C. U. SHILLING LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-25-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b> ADDRESS <b>1400 Chapin St., N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>FEB 24 58</b> 24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 24 1958

BUREAU V. 5

RECEIVED

2171 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4823 Leland St.</b>		d. STREET ADDRESS <b>4823 Leland St.</b>	
3. NAME OF DECEASED (Type or print) First <b>L.</b> Middle <b>Prescott</b> Last <b>FISHER</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 18, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>13</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cardiographic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Gov't.</b>	11. BIRTHPLACE (State or foreign country) <b>Rockville, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Geary A. Fisher</b>	
14. MOTHER'S MAIDEN NAME <b>Mattie Connelly</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name and dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>577-30-2874</b>		17. INFORMANT <b>Wife</b> Address <b>Camille R. Fisher</b> Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION RUPTURED</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL INFARCTION WITH ANEURYSM</b> DUE TO <b>6 1/2 hours</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 MINUTES</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept</b> , 19 <b>51</b> , to <b>Feb 1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JAN 30</b> , 19 <b>58</b> , and that death occurred at <b>5:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P.P. Andrews M.D.</b> M.D. <b>Washington 16 D.C.</b>		DATE SIGNED <b>2-2-58</b>	
PHYSICIAN'S NAME (Type) <b>P.P. ANDREWS M.D.</b>		<b>Washington 16 D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/4/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 5 '58</b>	24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

X

**RECEIVED**  
**BUREAU V. S.**  
 FEB 5 1966

## 2172 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring (Bethesda)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lebeaux Gardens</i>		d. STREET ADDRESS <i>12004 Milton St.</i>	
3. NAME OF DECEASED (Type or print) <i>SARAH First Middle Last FRANTZ G. FRANTZ</i>		4. DATE OF DEATH Month <i>FEB</i> Day <i>21</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>76 12-12-1881 76 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>76 yrs.</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Mason W. Gourley</i>		14. MOTHER'S MAIDEN NAME <i>Annie E. Gibson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Lena Plunkum</i>		Address <i>Lebeaux Gardens</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Heart Failure</i> DUE TO (c) <i>Anterior sclerotic, generalized</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 da.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>19</i> o. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 1957</i> to <i>Feb. 20, 1958</i> , that I last saw the deceased alive on <i>Feb. 20, 1958</i> , and that death occurred at <i>8:14 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert T. Thibadeau</i>		ADDRESS (Street, city or town, state) <i>10608 CONCORD ST</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBADEAU</i>		DATE SIGNED <i>2-21-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>2-25-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hine Co.</i>		ADDRESS <i>2901-14 St.</i>	
24. REC'D BY REGISTRAR <i>Feb 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form No. 10

WILM BROAD

W. B. B. B.

RECEIVED  
FEB 24 1958  
BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2173 CERTIFICATE OF DEATH

02138

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town</u> c. LENGTH OF STAY IN 1b		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bertie Beckwith</u> First Middle Last <b>4. DATE OF DEATH</b> <u>February 22</u> Month Day Year <u>1958</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Colored</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>May 8, 1877</u> <b>9. AGE</b> (In years last birthday) <u>80</u> yrs. <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A</u>		<b>13. FATHER'S NAME</b> <u>James Fleming</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Emily Talley</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Joseph Frazier, German town, Md</u> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Left hemiplegia</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. _____ 19 _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I attended the deceased from</b> <u>9 June</u> , 19 <u>48</u> , to <u>22 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>21 Feb</u> , 19 <u>58</u> , and that death occurred at <u>11:50 A.M.</u> , from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>John G. Fawcett</u> M.D. <b>DATE SIGNED</b> <u>Dawsonville</u>		<b>PHYSICIAN'S NAME (Type)</b> <u>John G. Fawcett MD</u> <u>P.O. Bayel, Md</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>2/25/58</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Asbury</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>German town, Md</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert L. Sorden</u> ADDRESS <u>Rockville, Md</u> <b>24a. REC'D BY REGISTRAR</b> <u>DATE MAR 3 '58</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>W. S. Sorden</u>	

**BUREAU V. S.**

MAR 3 1959

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G225 2-13-58 et

## CERTIFICATE OF DEATH

02139

Reg. Dist. No.

2174

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Wash D.C.</u> 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash D.C.</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens</u>				d. STREET ADDRESS <u>6433-8th st N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>VIRGINIA</u> First		Middle <u>Freeman</u>		Last <u>Freeman</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/75</u>	9. AGE (In years last birthday) <u>82 1/2</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Taylor Green</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Julian Day Freeman</u> Address <u>6433 8th St NW</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 7, 1946</u> to <u>Feb 7, 1958</u> , that I last saw the deceased alive on <u>Feb 7, 1958</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u> M.D. <u>7852 16th St NW Wash 12</u>				DATE SIGNED <u>3/7/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>300 4th St N.E. Wash D.C.</u>				24a. REC'D BY REGISTRAR <u>Feb 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

67-20-876-07 Wn

BOND

BUREAU V. S.

FEB 10 1959

RECEIVED

2/10/59  
2:15 PM  
FEB 10 1959



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2176 CERTIFICATE OF DEATH

02141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SUBURBAN HOSPITAL</b>		d. STREET ADDRESS <b>807 S. BELGRADE ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle <b>EILEEN</b> Last <b>FROST</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 27, 1956</b>
9. AGE (In years last birthday) <b>1-11-26</b>		IF UNDER 1 YEAR: Months <b>11</b> Days <b>26</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ALBERT L. FROST</b>		14. MOTHER'S MAIDEN NAME <b>RITA P. O'DONNELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ALBERT L. FROST, 807 S. Belgrade Rd., Silver Spr..</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure — suffocation</b> DUE TO (b) <b>Tracheo-bronchitis, acute</b> DUE TO (c) <b>500x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 Feb., 1958</b> , to <b>17 Feb., 1958</b> , that I last saw the deceased alive on <b>17 Feb., 1958</b> , and that death occurred at <b>9:54</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Bier</b>		ADDRESS (Street, city or town, state) <b>9028 Woodland Dr., Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT A. BIER</b>		DATE SIGNED <b>2/18/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/20/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wanner E. Humphrey</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Alber...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8561 24 33 1958

RECEIVED

02142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>11 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>Rockville, Md</u>	
3. NAME OF DECEASED (Type or print) <u>Gartner</u> <u>Albert L</u>		4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>48</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/9/85</u>
9. AGE (In years last birthday) yrs. <u>72</u>		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assist. Supv. Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Game Reserve</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Gartner</u>		14. MOTHER'S MAIDEN NAME <u>Martha Girland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Marion Cooley (Friend)</u>		Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>emphysema</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>13 Dec 48</u> to <u>10 Feb 49</u> , that I last saw the deceased alive on <u>9 Feb 1955</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2614 Summit Ave</u> DATE SIGNED <u>10 Feb 1955</u> ACTUAL SIGNATURE <u>Gordon S Rosenberg</u> M.D. PHYSICIAN'S NAME (Type) <u>G. Rosenberger</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Gaithersburg R F D Md.</u>		22d. LOCATION (City, town, or county) (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest G Gartner, Gaithersburg Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1958 64 223

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02143

2178 Item 6 Film 226 3-3-58 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6804 Fairfax Rd.</u>			d. STREET ADDRESS <u>6804 Fairfax Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Allen George Gartner</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/3/1893</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Geo. Gartner</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>WW yes</u> <u>WW 1</u>		
16. SOCIAL SECURITY NO. <u>Police Record</u>			17. INFORMANT <u>Police Record</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute pancreatitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Suitland, Maryland</u>	(County) <u></u>	(State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/21/58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>	(State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>			ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>
24b. REGISTRAR'S SIGNATURE <u></u>					



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

RECEIVED  
FEB 24 1958  
BUREAU X B

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2179

CERTIFICATE OF DEATH

02144  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>133 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NMMC, Bethesda Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>2406 19th Street N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Samuel Robert GATES</b>		4. DATE OF DEATH Month Day Year <b>February 3 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 November 1865</b>
9. AGE (In years last birthday) yrs. <b>92</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>92</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Basil Leonard GATES</b>		14. MOTHER'S MAIDEN NAME <b>Anna R. GARNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Spanish Am War</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>(Son) Robert Marshall GATES (Same as #2)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction, myocardium</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>ASHD</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>unknown</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>23 September, 1957</b> , to <b>3 February, 1958</b> , that I last saw the deceased alive on <b>3 February, 1958</b> , and that death occurred at <b>9:05 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. U. Shilling</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 2-4-58</b>	
PHYSICIAN'S NAME (Type) <b>C. U. SHILLING LT MC USA</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE Funeral Home 4th and Massachusetts Ave. N.E.</b>		24a. REC'D. BY REGISTRAR <b>W. K. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU Y. F.

FEB. 6 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2180

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

02145.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>37 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Falls Church</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>83 x .5</b> d. STREET ADDRESS <b>617 Poular Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>George John GERCKE</b>				4. DATE OF DEATH Month Day Year <b>February 8 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 February 1904</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motion Picture Producer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>George W. GERCKE</b>				14. MOTHER'S MAIDEN NAME <b>Minnette FRANCIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>133 16 8316</b>		17. INFORMANT <b>(Wife) Sarah A. GERCKE (Same as #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of tongue, post irradiated</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>2 January</b> , 19 <b>58</b> , to <b>8 February</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8 February</b> , 19 <b>58</b> , and that death occurred at <b>5:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md</b> DATE SIGNED <b>2-9-58</b>							
ACTUAL SIGNATURE <b>[Signature]</b>				M.D. <b>U.S. Naval Hospital, Bethesda Md</b>			
PHYSICIAN'S NAME (Type) <b>W.E. GREER</b>				LT MC USNR <b>U.S. Naval Hospital, Bethesda Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2-11-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Pawler's Sons</b>				ADDRESS <b>1756 Penn. Ave. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>FEB 11 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY JOHN T. HINE—HYATT'S 10 THOMPSON SUBMACHINE GUNS

BUREAU V. S.

FEB 11 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2131

## CERTIFICATE OF DEATH

02146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>67 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>910 - 10th Street, Apt. A-2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Janet</b> Middle <b>Leland</b> Last <b>Gilmore</b>				4. DATE OF DEATH Month <b>February</b> Day <b>10</b> , Year <b>19 58</b>			
5. SEX <b>White Female</b>		6. COLOR OR RACE <b>Female</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14, 1952</b>	
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>26</b>		IF UNDER 24 HRS. Hours <b>26</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Greece</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Leland Gilmore</b>				14. MOTHER'S MAIDEN NAME <b>Celeste Funeri</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas Pneumonia</b> <b>587.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cystic Fibrosis of Pancreas</b> DUE TO (c) <b>Acute Cor pulmonale</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 Months</b> <b>Since birth.</b> <b>7 days.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>o. m.</b> <b>19</b> <b>p. m.</b>		Month, <b>19</b> Day, <b>19</b> Year, <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>December 5, 19 57</b> , to <b>February 10, 19 58</b> , that I last saw the deceased alive on <b>February 10, 19 58</b> , and that death occurred at <b>10:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Thomas F. Dolan, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>THOMAS F. DOLAN, JR. M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/13/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Rita's</b>		22d. LOCATION (City, town, or county) (State) <b>Fayette County Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

FEB 13 1953

RECEIVED

2103

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>8630 Piney Branch Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Wilmina Katherine Coldsworthy</u>				4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-4-90</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min. <u>58</u>		IF UNDER 24 HRS Months <u>6</u> Days <u>17</u> Hours <u>19</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife &amp; Proof Reader</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Fred J. Ubinger</u>				14. MOTHER'S MAIDEN NAME <u>Ella Montgomery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>181-16-9128</u>		17. INFORMANT <u>Old Records - Husband</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis &amp; arteriosclerosis both renal &amp; weeks plus</u> DUE TO (b) <u>Hypertensive C.V.R. disease</u> DUE TO (c) <u>442x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the breast &amp; metastases</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 17, 1958</u> to <u>Feb 17, 1958</u> , that I last saw the deceased alive on <u>Feb 17, 1958</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.W. Danis</u> M.D.				DATE SIGNED <u>2-17-58</u>			
PHYSICIAN'S NAME (Type) <u>A.W. Danis</u>				ADDRESS (Street, city or town, state) <u>Silver Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. &amp; BURIAL</u>		<u>2/22/58</u>		<u>Alleghany Co. Mem. Pk. Cemetery, Near Mt. Royal, Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u>				24a. REC'D BY REGISTRAR <u>843 Silver Spring, Md</u>		24b. REGISTRAR'S SIGNATURE <u>DATE 2-4-58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

BUREAU V. 1

FEB 24 1958

RECEIVED

2182 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONT.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>7810 STRATFORD RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>THOMAS</u> Last <u>GRAHAM</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 30 1886</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE (In years last birthday) <u>72</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>FREDERICK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN T THAMPS</u>		14. MOTHER'S MAIDEN NAME <u>SARAH MANTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>GEORGE V GRAHAM 7810 STRATFORD RD.</u>	
17. INFORMANT <u>Address BETHESDA MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>266X</u> (b) <u>Advanced coronary sclerosis</u> DUE TO (c) <u>Hypertension and general arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u> <u>10 yrs +</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>1946</u> to <u>Feb 16</u> , 1958, that I last saw the deceased alive on <u>Jan</u> , 1958, and that death occurred at <u>5:20 P.M.</u> , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <u>3921 Ingoman St NW</u>		DATE SIGNED <u>2-16-58</u>	
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D.		PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u> <u>WASH DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>FREDERICK, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Buckle</u> ADDRESS <u>WASH, D.C.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Wash DC</u>



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERK	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF TOWNSHIP CLERK	
22. SIGNATURE OF VILLAGE CLERK		23. SIGNATURE OF CITY CLERK		24. SIGNATURE OF STATE CLERK	
25. SIGNATURE OF FEDERAL CLERK		26. SIGNATURE OF MARSHAL		27. SIGNATURE OF SHERIFF	
28. SIGNATURE OF JUDGE		29. SIGNATURE OF SHERIFF		30. SIGNATURE OF CORONER	
31. SIGNATURE OF DISTRICT ATTORNEY		32. SIGNATURE OF COUNTY CLERK		33. SIGNATURE OF TOWNSHIP CLERK	
34. SIGNATURE OF VILLAGE CLERK		35. SIGNATURE OF CITY CLERK		36. SIGNATURE OF STATE CLERK	
37. SIGNATURE OF FEDERAL CLERK		38. SIGNATURE OF MARSHAL		39. SIGNATURE OF SHERIFF	
40. SIGNATURE OF JUDGE		41. SIGNATURE OF SHERIFF		42. SIGNATURE OF CORONER	
43. SIGNATURE OF DISTRICT ATTORNEY		44. SIGNATURE OF COUNTY CLERK		45. SIGNATURE OF TOWNSHIP CLERK	
46. SIGNATURE OF VILLAGE CLERK		47. SIGNATURE OF CITY CLERK		48. SIGNATURE OF STATE CLERK	
49. SIGNATURE OF FEDERAL CLERK		50. SIGNATURE OF MARSHAL		51. SIGNATURE OF SHERIFF	
52. SIGNATURE OF JUDGE		53. SIGNATURE OF SHERIFF		54. SIGNATURE OF CORONER	
55. SIGNATURE OF DISTRICT ATTORNEY		56. SIGNATURE OF COUNTY CLERK		57. SIGNATURE OF TOWNSHIP CLERK	
58. SIGNATURE OF VILLAGE CLERK		59. SIGNATURE OF CITY CLERK		60. SIGNATURE OF STATE CLERK	
61. SIGNATURE OF FEDERAL CLERK		62. SIGNATURE OF MARSHAL		63. SIGNATURE OF SHERIFF	
64. SIGNATURE OF JUDGE		65. SIGNATURE OF SHERIFF		66. SIGNATURE OF CORONER	
67. SIGNATURE OF DISTRICT ATTORNEY		68. SIGNATURE OF COUNTY CLERK		69. SIGNATURE OF TOWNSHIP CLERK	
70. SIGNATURE OF VILLAGE CLERK		71. SIGNATURE OF CITY CLERK		72. SIGNATURE OF STATE CLERK	
73. SIGNATURE OF FEDERAL CLERK		74. SIGNATURE OF MARSHAL		75. SIGNATURE OF SHERIFF	
76. SIGNATURE OF JUDGE		77. SIGNATURE OF SHERIFF		78. SIGNATURE OF CORONER	
79. SIGNATURE OF DISTRICT ATTORNEY		80. SIGNATURE OF COUNTY CLERK		81. SIGNATURE OF TOWNSHIP CLERK	
82. SIGNATURE OF VILLAGE CLERK		83. SIGNATURE OF CITY CLERK		84. SIGNATURE OF STATE CLERK	
85. SIGNATURE OF FEDERAL CLERK		86. SIGNATURE OF MARSHAL		87. SIGNATURE OF SHERIFF	
88. SIGNATURE OF JUDGE		89. SIGNATURE OF SHERIFF		90. SIGNATURE OF CORONER	
91. SIGNATURE OF DISTRICT ATTORNEY		92. SIGNATURE OF COUNTY CLERK		93. SIGNATURE OF TOWNSHIP CLERK	
94. SIGNATURE OF VILLAGE CLERK		95. SIGNATURE OF CITY CLERK		96. SIGNATURE OF STATE CLERK	
97. SIGNATURE OF FEDERAL CLERK		98. SIGNATURE OF MARSHAL		99. SIGNATURE OF SHERIFF	
100. SIGNATURE OF JUDGE		101. SIGNATURE OF SHERIFF		102. SIGNATURE OF CORONER	

BUREAU V. S.

FEB 19 1932

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02149

## 2183 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland</u>		c. LENGTH OF STAY IN 1b <u>6 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Nursing Home</u>			d. STREET ADDRESS <u>513 Philadelphia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>MAUDE</u> Last <u>GRIFFIN</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 15, 1864</u>		9. AGE (In years last birthday) <u>93</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rural Homeowner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Holyax, Nova Scotia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Not Available</u>			14. MOTHER'S MAIDEN NAME <u>Not Available</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Mrs. Clara C. Gould, 513 Philadelphia Ave T.P. Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Renal Vascular Disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis, Accelerated</u> DUE TO (c) <u>10-year</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Sep 1</u> , 1957, to <u>2 Feb</u> , 1958, that I last saw the deceased alive on <u>31 Jan</u> , 1958, and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>M.B. Queen</u>		ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u>		DATE SIGNED <u>2 Feb 1958</u>	
PHYSICIAN'S NAME (Type) <u>M. B. QUEEN</u>		TAKOMA PARK MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial</u>	22b. DATE THEREOF <u>Feb. 5, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stoughton Mass</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>5</u>	
				24b. REGISTRAR'S SIGNATURE	

RECEIVED

1958 JUL 13

BUREAU Y. 1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10	
CERTIFICATE OF DEATH	
Date of Death	
1. Name of Deceased	
2. Sex	
3. Race	
4. Date of Birth	
5. Place of Birth	
6. Usual Residence	
7. Cause of Death	
8. Date of Death	
9. Place of Death	
10. Signature of Physician	
11. Signature of Registrar	
12. Signature of Coroner	
13. Signature of Medical Examiner	
14. Signature of Health Officer	
15. Signature of County Health Officer	
16. Signature of City Health Officer	
17. Signature of State Health Officer	
18. Signature of Federal Health Officer	
19. Signature of International Health Officer	
20. Signature of Other Health Officer	

## 2104 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>6 days.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hospital</i>				d. STREET ADDRESS <i>6 East Franklin Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Katie</i> Middle <i>Elizabeth</i> Last <i>Gross</i>				4. DATE OF DEATH Month <i>2</i> Day <i>19</i> Year <i>1958</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-4-74</i>	
9. AGE (In years last birthday) <i>84 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>ISAAC Tyler</i>				14. MOTHER'S MAIDEN NAME <i>Mary BEDSWORTH (WILSON)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>William Gross</i> Address <i>6 E FRANKLIN AVE SIL SPRING MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Thrombosis Left Coronary Artery</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>JAN</i> , 19 <i>58</i> , to <i>19 FEB</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>18 FEB</i> , 19 <i>58</i> , and that death occurred at <i>10:35 A</i> .M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>9013 FLOWER AVE.</i> DATE SIGNED ACTUAL SIGNATURE <i>L.B. Snow</i> M.D. PHYSICIAN'S NAME (Type) <i>SILVER SPRING, MARYLAND</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2-22-58</i>		<i>Prospect Hill</i>		<i>Washington DC</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Real Funeral Home</i> ADDRESS <i>4812 G. Ave.</i>				24a. REC'D BY REGISTRAR <i>W. Brown</i>		24b. REGISTRAR'S SIGNATURE <i>W. Brown</i>	
DATE <i>FEB 24 '58</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. CAUSE OF DEATH		10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE		19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWER	
29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER	
33. SIGNATURE OF INTERVIEWER		34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF INTERVIEWER	
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49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWER		52. SIGNATURE OF INTERVIEWER	
53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWER		55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWER	
57. SIGNATURE OF INTERVIEWER		58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF INTERVIEWER	
65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWER		67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER	
69. SIGNATURE OF INTERVIEWER		70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWER		76. SIGNATURE OF INTERVIEWER	
77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWER		79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWER	
81. SIGNATURE OF INTERVIEWER		82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF INTERVIEWER	
89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER		91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER	
93. SIGNATURE OF INTERVIEWER		94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWER	

BUREAU V. 1

FEB 24 1958

RECEIVED

18 Feb 1958

2100 Spring Ave

2100 Spring Ave



## 2184 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edgar</u> Last <u>HAMILTON</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 June 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>58</u> Min.	IF UNDER 24 HRS. Months <u>6</u> Days <u>9</u> Hours <u>58</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administration, C &amp; P Telephone Company</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Massachusetts</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward HAMILTON</u>		14. MOTHER'S MAIDEN NAME <u>Sarah GUINN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW-I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Wife) Mrs. Evelyn M. Hamilton (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the stomach with metastases.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>18 January, 19 58</u> , to <u>13 February, 19 58</u> , that I last saw the deceased alive on <u>12 February, 19 58</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Muth</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>2-13-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Muth, LT, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-17-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>Feb 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	
25. FUNERAL HOME <u>Simmons Funeral Home, 1661 Goodhope Rd., S.E.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. B.

FEB 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2185 CERTIFICATE OF DEATH

02152

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>2727 Jasper St., S.E.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sharon</b> Middle <b>Kay</b> Last <b>HAMMER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 April 1957</b>
9. AGE (In years last birthday) yrs. <b>10</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert W. HAMMER</b>		14. MOTHER'S MAIDEN NAME <b>Kay M. VANROEKEL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(Father) Robert W. Hammer</b>		Address <b>(Same As #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypernatremia</b> <b>053.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gastroenteritis acute</b> DUE TO (c) <b>Staphylococcal enterocolitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>2 weeks</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 February, 19 58</b> to <b>7 February, 19 58</b> , that I last saw the deceased alive on <b>7 February, 19 58</b> , and that death occurred at <b>5:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>2-7-58</b>			
ACTUAL SIGNATURE <b>Kenneth W. Sell</b> M.D.		DATE SIGNED <b>2-7-58</b>	
PHYSICIAN'S NAME (Type) <b>Kenneth W. SELL, LT, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-11-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		ADDRESS <b>517 11th Street SE Washington D.C.</b>	
24a. REC'D BY REGISTRAR <b>FEB 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

2051253XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 11, 1958

BUREAU V. S.

112153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Md.</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Kensington</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>3400 Bexhill Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>LONON</b> Last <b>HARRISON</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>15</b> Year <b>58</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/26/1901</b>			
9. AGE (In years lost birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>20</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Huggins-Harrison</b>		11. BIRTHPLACE (State or foreign country) <b>Marion, N.C.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>David N. Lonon</b>				14. MOTHER'S MAIDEN NAME <b>Hester Yancey</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-30-3773</b>					
17. INFORMANT <b>Blake B. Harrison, Jr. - Son</b>				Address <b>Same as Item #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis of abdomen</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Meta-static carcinoma</b> DUE TO (c) <b>Origin undetermined</b>								INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <b>46</b> , to <b>Feb 16</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 15</b> , 19 <b>58</b> , and that death occurred at <b>1258 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3921 Ingomar St. N.W. Wash 15 DC</b> DATE SIGNED <b>2/16/58</b>									
ACTUAL SIGNATURE <b>Stewart Clapp</b>				PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/19/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Marion, N.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>FEB 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			

VS A15 (4)  
ISM 10/57

VS A15 (4)  
ISM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
 CERTIFICATE OF DEATH

**RECEIVED**  
 FEB 20 1973  
 BUREAU V. S.

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
PLACE OF DEATH		CITY	
MEMPHIS, TENNESSEE		MEMPHIS	
AGE		SEX	
35		MALE	
RACE		OCCUPATION	
WHITE		ATTORNEY	
BIRTH DATE		BIRTH PLACE	
JANUARY 5, 1933		ALABAMA	
MARRIAGE DATE		MARRIAGE PLACE	
MAY 12, 1957		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		SUICIDE	
IMMEDIATE CAUSE		MEDIUM	
CORONARY THROMBOSIS		FIRE	
PREEXISTING DISEASES		FINDINGS	
HYPERTENSION		CORONARY Atherosclerosis	
DIABETES		MURDER	
SMOKING		FINDINGS	
YES		CORONARY Atherosclerosis	
ALCOHOL		MURDER	
NO		FINDINGS	
DRUGS		CORONARY Atherosclerosis	
NO		MURDER	
OTHER		FINDINGS	
NO		CORONARY Atherosclerosis	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE	
APRIL 4, 1968		APRIL 4, 1968	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02154

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**1. PLACE OF DEATH**

a. COUNTY Montgomery **MARYLAND**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
Olney

c. LENGTH OF STAY IN lb  
5 hrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Maryland b. COUNTY Montg.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
26 Rockville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  
Montg. Co, Gen, Hosp,

d. STREET ADDRESS  
1 Lincoln Park

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED**  
(Type or print)

William Harrison

**4. DATE OF DEATH**

Feb. 24, 1958

Year  
19

**5. SEX**

male

**6. COLOR OR RACE**

col.

**7. MARRIED ☐ NEVER MARRIED ☒**

WIDOWED ☐

DIVORCED ☐

**8. DATE OF BIRTH**

2/23/1908

**9. AGE** (In years last birthday)

50 yrs.

**IF UNDER 1 YEAR**

Months      Days     

**IF UNDER 24 HRS.**

Hours      Min.     

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

laborer

**10b. KIND OF BUSINESS OR INDUSTRY**

**11. BIRTHPLACE** (State or foreign country)

Fla.

**12. CITIZEN OF WHAT COUNTRY?**

USA

**13. FATHER'S NAME**

Unknown

**14. MOTHER'S MAIDEN NAME**

Unknown

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT**

Police Record

**Address**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Shock

981X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hemorrhage

DUE TO

(c) Shot Gun wound in left groin

**INTERVAL BETWEEN ONSET AND DEATH**

6 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Fracture of left pelvis. Severance of bowel

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
Reported shot while forceing entrance in accused home

**20c. TIME OF INJURY**

Hour 3:00 o. m.

**Month, Day, Year**

2/24 1958

**20d. INJURY OCCURRED**

While of work ☐ Not while of work ☒

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

home

**20f. (City or town)**

nr Norbeck

**(County)**

Montg.

**(State)**

Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

**ACTUAL SIGNATURE**

Frank J. Broschart

M.D.

**CHIEF MEDICAL EXAMINER ☐**

**ASSISTANT MEDICAL EXAMINER ☐**

**DEPUTY MEDICAL EXAMINER ☒**

**DATE SIGNED**

2/24/58

**EXAMINER'S NAME** (Type)

Frank J. Broschart

**22a. BURIAL, CREMATION, REMOVAL (Specify)**

Burial

**22b. DATE THEREOF**

2/28/58

**22c. NAME OF CEMETERY OR CREMATORY**

Lincoln Park..

**22d. LOCATION** (City, town, or county)

Rockville, Md.

**(State)**

**23. FUNERAL DIRECTOR'S SIGNATURE**

Robert L. Snodgrass

**ADDRESS**

Rockville, Md.

**24a. REC'D BY REGISTRAR**

DATE

MAR 3 '58

**24b. REGISTRAR'S SIGNATURE**

[Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF  
HEALTH DEPT.

H

RECEIVED  
MAR 3 1959

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAR 3 1959  
BUREAU V. B.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

2188

FOR STATE  
HEALTH DEPT.

## 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Gaithersburg - R-2

c. LENGTH OF STAY IN 1b

life

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

md

b. COUNTY

montg

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Gaithersburg - R-2

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Etchison

d. STREET ADDRESS

Etchison

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒3. NAME OF  
DECEASED  
(Type or print)

First

Thomas

Middle

Franklin Hawkins

Last

4. DATE  
OF  
DEATH

Month

Feb

Day

9

Year

1958

## 5. SEX

male

## 6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

## 8. DATE OF BIRTH

4-5-1889

9. AGE (In years  
last birthday)

68 yrs.

## IF UNDER 1 YEAR

Months

Days

Hours

Min.

## IF UNDER 24 HRS.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

merchant

## 10b. KIND OF BUSINESS OR INDUSTRY

Retail Grocery

md

## 11. BIRTHPLACE (State or foreign country)

md

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Jos. C. Hawkins

## 14. MOTHER'S MAIDEN NAME

Nettie E. Duval

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

217-32-0801

## 17. INFORMANT

Address

Ernest Hawkins - Gaith. Md R-2

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

420.1 DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

sudden

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

## 20c. TIME OF INJURY

Month, Day, Year

Hour o. m.  
p. m.

19

## 20d. INJURY OCCURRED

While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL  
SIGNATURE

Frank J. Brosnart

M.D.

CHIEF MEDICAL EXAMINER ☐

## DATE SIGNED

EXAMINER'S  
NAME (Type)

FRANK J. Brosnart

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

2-9-58

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

Feb. II

1958

## 22c. NAME OF CEMETERY OR CREMATORY

Mt. Tabor

## 22d. LOCATION (City, town, or county)

Etchison

(State)

Md.

## 23. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

Roy W. Barber

Laytonsville, Md.

## 24a. REC'D BY REGISTRAR

DATE

## 24b. REGISTRAR'S SIGNATURE

W. J. Search

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH

BUREAU V. S.

FEB 11 1958

RECEIVED

Printed April 1, 1955 at Labor



## 2105 CERTIFICATE OF DEATH

02156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Manzella</u> Last <u>Hightman</u>				4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-22-94</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Abner B. Bingham</u>				14. MOTHER'S MAIDEN NAME <u>Annie Roberson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>718-18-0017</u>			
17. INFORMANT <u>Washington San + Hosp. Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Uterus &amp; Metastases</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> 174X INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thromboses of Vena Cava and Lungs</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Jan 19, 1958</u> , to <u>Feb 7, 1958</u> , that I last saw the deceased alive on <u>Feb 4, 1958</u> , and that death occurred at <u>5:25 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Witlock</u>				DATE SIGNED <u>2-4-58</u>			
PHYSICIAN'S NAME (Type) <u>J. M. Witlock</u>				ADDRESS (Street, city or town, state) <u>2701 Carroll Ave</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burkittsville Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Burkittsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, place, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.  
FEB 6 1958

RECEIVED

Item 9 Film G226 3-20-58 et  
2189 CERTIFICATE OF DEATH

02157

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>Maple View Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Dionysius</u> Middle <u>Hilton</u> Last <u>Hilton</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1862</u>
9. AGE (In years last birthday) <u>95 1/4</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>William T. Griffin - Grandson</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (o) <u>Cerebrovascular accident</u> 331X DUE TO <u>Cerebral arteriosclerosis thrombotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>of left internal carotid artery</u> (c) <u>Septal myocardial infarction</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Feb. 17</u> , 19 <u>58</u> to <u>Feb. 20</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Feb. 20</u> , 19 <u>58</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Gray Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Chevy Chase Dr. Chevy Chase 15, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George A. Gray Jr.</u>		DATE SIGNED <u>2/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>	22d. LOCATION (City, town, or county) (State) <u>Damascus, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>FEB 26 '58</u>	24b. REGISTRAR'S SIGNATURE <u>  </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		10/10/28		MEMPHIS, TENN.		4/4/68		MEMPHIS, TENN.		HEART DISEASE		NATURAL		[Signature]		[Signature]	
13. FULL DESCRIPTION OF DISEASE OR INJURY		14. FULL DESCRIPTION OF DISEASE OR INJURY		15. FULL DESCRIPTION OF DISEASE OR INJURY		16. FULL DESCRIPTION OF DISEASE OR INJURY		17. FULL DESCRIPTION OF DISEASE OR INJURY		18. FULL DESCRIPTION OF DISEASE OR INJURY		19. FULL DESCRIPTION OF DISEASE OR INJURY		20. FULL DESCRIPTION OF DISEASE OR INJURY		21. FULL DESCRIPTION OF DISEASE OR INJURY		22. FULL DESCRIPTION OF DISEASE OR INJURY		23. FULL DESCRIPTION OF DISEASE OR INJURY		24. FULL DESCRIPTION OF DISEASE OR INJURY	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	

BUREAU V. B

FEB 26 1968

RECEIVED



1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness. It should be filled out as soon as possible after death, and should be signed by the physician or other qualified person who has attended the deceased during his last illness. It should be filed in the office of the Registrar of Deaths, Department of Health, Baltimore, Maryland.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2190 CERTIFICATE OF DEATH

02158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>3622 Milford Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Floyd</b> Middle <b>Garfield</b> Last <b>Hoback</b>				4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 16, 1882</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Samuel Hoback</b>				14. MOTHER'S MAIDEN NAME <b>Alice Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unascertainable</b>			
17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILATERAL ADRENAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>VASCULAR OCCLUSION, SMALL + LARGE BOWEL; MALIGNANT CARCINOID</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>OF SMALL BOWEL</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bethesda</b>		(County) <b>Montgomery</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>February 6, 19 58</b> , to <b>February 18, 19 58</b> , that I last saw the deceased alive on <b>February 18, 19 58</b> , and that death occurred at <b>6:13 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Samuel Charache</b> M. D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Samuel Charache, M. D.</b>				DATE SIGNED <b>FEB 19 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/22/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland</b>		24a. REC'D BY REGISTRAR <b>B 2 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Rede...</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>				ADDRESS			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurriness.

BUREAU V. R.

FEB 24 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02159

2191

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>2325 15th Street, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>E</b> Last <b>HOLSBERRY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 April 1899</b>
9. AGE (In years last birthday) yrs. <b>58</b>		IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>	IF UNDER 24 HRS. Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Euphritis HOLSBERRY</b>		14. MOTHER'S MAIDEN NAME <b>Ruhala STUMP</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW-I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Wife) Mrs. Frances W. HOLSBERRY</b>		Address (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction Myocardium about 2 hours</b> DUE TO (b) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>about 2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>31 January, 19 58</b> , to <b>2 February, 19 58</b> , that I last saw the deceased alive on <b>1 February, 19 58</b> , and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T.S. DUNN, JR.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 2-3-58</b>	
PHYSICIAN'S NAME (Type) <b>T.S. DUNN, JR., LT, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkins, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>FEB 6 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>R.A. Pumphrey</b>		25. WISCONSIN AVE., Bethesda, Md.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU W. B.

FEB. 6 1958

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4407 Everett St</u>	
3. NAME OF DECEASED (Type or print) <u>Blair Ernest Holt</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 16 - '18</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>store</u>	
11c. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Holt</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 2/25/57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Augusta, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '58</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE  
DEPT. OF HEALTH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. E.

FEB 24 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2193

## CERTIFICATE OF DEATH

Reg. Dist. No.

02161

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>47X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home</b>		d. STREET ADDRESS <b>2500 Q St., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>G.</b> Last <b>Hughes</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 7, 1900</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Hoosick Falls, N.Y.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>PATRICK Gannon</b>		14. MOTHER'S MAIDEN NAME <b>Mary Sherin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Patricia Hughes-- Room 315 Senate O.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> <b>193.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemiplegia--Invalidism</b> DUE TO (c) <b>Glioma--grade IV--Frontal lobe</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 mos.</b> <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1958</b> , to <b>Feb 8, 1958</b> , that I last saw the deceased alive on <b>Jan 15, 1958</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard E. Nunez</b>		DATE SIGNED <b>2-23-58 R St. N.W. Feb 8, 1958</b>	
PHYSICIAN'S NAME (Type) <b>BERNARD E. NUNEZ MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>	22b. DATE THEREOF <b>2/13/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>HOOSICK FALLS, NEW YORK</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey Silver Spring</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. E. Humphrey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "J. M. ..."]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "FEB 11 1936"]		PLACE OF DEATH [Faint text, possibly "HOME"]		CITY [Faint text, possibly "BALTIMORE"]	
COUNTY [Faint text, possibly "BALTIMORE"]		STATE [Faint text, possibly "MD"]		ZIP CODE [Faint text, possibly "21201"]	
OCCUPATION [Faint text, possibly "CLERK"]		CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "J. M. ..."]		SIGNATURE OF CORONER [Faint text, possibly "J. M. ..."]		SIGNATURE OF REGISTRAR [Faint text, possibly "J. M. ..."]	
SIGNATURE OF WITNESS [Faint text, possibly "J. M. ..."]		SIGNATURE OF WITNESS [Faint text, possibly "J. M. ..."]		SIGNATURE OF WITNESS [Faint text, possibly "J. M. ..."]	

**RECEIVED**  
**BUREAU V. 1**  
**FEB 11 1936**

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

2106

## CERTIFICATE OF DEATH

02162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>District of Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>(Anna)</u> Last <u>Nyath</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Jewish</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/94</u>	
9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Philip Gantz</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>9</u>		17. INFORMANT Address <u>Daughter &amp; Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 9</u> , 19 <u>58</u> , to <u>Feb 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 14</u> , 19 <u>58</u> , and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>533 Riggs Pl. N.E.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Arthur S. Bresler</u> M.D. <u>Washington D.C.</u> PHYSICIAN'S NAME (Type) <u>ARTHUR S. BRESLER</u> <u>Washington D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>FEB 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TALMUD TORAH CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CONGRESS HGTS. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>B. Danzansky &amp; Sons - 3501-14th St NW - Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF OTHER OFFICIAL</p>	

BUREAU V. 2

FEB 19 1953

RECEIVED

2194

## CERTIFICATE OF DEATH

Item 3, Film G-229 5/21/58, vac.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Wash. D.C.</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4412 Greenwich Pkwy. N.W. 47x 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>T. P.</b> Last <b>Jaycox</b>				4. DATE OF DEATH <b>10/25 Month, Feb. 23</b> Day <b>19</b> Year <b>58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-30-76</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR <b>0</b> Months <b>28</b> Days		IF UNDER 24 HRS. <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York, (East Fishkill) U.S.A.</b>	
13. FATHER'S NAME <b>Warren Horton</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Tilton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT (Name) <b>Warren C. Jaycox</b>		Address <b>xxxxxx xxxxxxxx Item# 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> <b>broncho pneumonia, bilat.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>thrombophlebitis, rt. leg.</b> DUE TO (c) <b>cerebral vascular accident</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>5 days</b> <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>54</b> , to <b>23 Feb</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>22 Feb</b> , 19 <b>58</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John M. Wyman</b>				ADDRESS (Street, city or town, state) <b>7659 Georgetown Road Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>John M. Wyman</b>				DATE SIGNED <b>23 Feb 58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>2/23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mayflower</b>		22d. LOCATION (City, town, or county) (State) <b>Duxbury, Mass.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				24a. RECEIVED BY REGISTRAR <b>FEB 26 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF DEATH April 4, 1968	
5. PLACE OF DEATH Room 306, LBJ Library, Washington, D.C.		6. CITY Washington, D.C.		7. STATE District of Columbia		8. COUNTY District of Columbia	
9. OCCUPATION Attorney		10. MARITAL STATUS Single		11. RACE White		12. RELIGION Methodist	
13. CAUSE OF DEATH Suicide by gunshot		14. MANNER OF DEATH Homicide		15. ICD-9 CODE 276.20		16. MEDICAL HISTORY None	
17. SIGNATURE OF PHYSICIAN [Signature]		18. SIGNATURE OF CORONER [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF DECEASED [Signature]	
21. DATE OF SIGNATURE April 4, 1968		22. DATE OF SIGNATURE April 4, 1968		23. DATE OF SIGNATURE April 4, 1968		24. DATE OF SIGNATURE April 4, 1968	

**RECEIVED**  
FEB 26 1968  
BUREAU V. E.

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the State Department of Health, Baltimore, Maryland.

2. The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.

3. The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.

4. The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.

5. The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.

6. The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.

7. The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.

8. The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.

9. The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.

10. The information furnished on this certificate is for the use of the State Department of Health and is not to be used for any other purpose.



2195

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>56</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 Hilltop Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EBER W. JEFFERY</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/13/1895</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>	11. IF UNDER 24 HRS. Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Supervisory Dir. History, DC</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jerod W. Jeffery</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	
16. SOCIAL SECURITY NO. <b>W.W.# 1</b>		17. INFORMANT <b>Maurine A. Jeffery 109 Hilltop Rd., S.S. Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARDIOVASCULAR-RENAL DISEASE</b> DUE TO (c) <b>SEV. YRS.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>ONE HOUR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>472X VIRUS PNEUMONITIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1958</b> to <b>Feb 7, 1958</b> that I last saw the deceased alive on <b>Feb 7, 1958</b> and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>6940 Piney Branch Rd., N.W. 2/7/58</b>	
ACTUAL SIGNATURE <b>Lynwood Heiges</b>		PHYSICIAN'S NAME (Type) <b>LYNWOOD HEIGES, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>2/11/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Quincy, Ill.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.,</b>		24a. REC'D BY REGISTRAR <b>DATE 13 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

RESIDENT

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF DEATH

RESIDENT

CAUSE OF DEATH

DATE OF DEATH

DECEASED

DATE OF DEATH

DECEASED

DECEASED

DATE OF DEATH

DECEASED

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DECEASED

BUREAU V. 1

FEB 13 1958

RECEIVED



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MORTUARY

MARYLAND

SEX

AGE

CAUSE OF DEATH

DATE OF DEATH

3810 Lindenwood Street

3810 Lindenwood Street

58

100

100

100

100

WHITE

MALE

100

100

BUREAU V. 81

FEB 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2107 CERTIFICATE OF DEATH

Reg. Dist. No. 02166

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>65 Allison Street, NE</u>			
3. NAME OF DECEASED (Type or print) First <u>Johnson</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 5, 1958</u>	9. AGE (In years last birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>58</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Thomas Eugene Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Betty Jean Mannon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Father</u>		Address <u>same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> DUE TO <u>Immaturity</u> (c) <u>Immaturity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>7 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	Month, <u>19</u>	Day, <u>19</u>	Year, <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Washington, D.C.</u>	(County) <u>Washington</u>
21. I certify that I attended the deceased from <u>Feb 5, 1958</u> to <u>Feb 6, 1958</u> , that I last saw the deceased alive on <u>Feb 6, 1958</u> , and that death occurred at <u>Washington, D.C.</u> M, from the causes and on the date stated above.							DATE SIGNED <u>2-6-58</u>
ACTUAL SIGNATURE <u>Samuel M. Bageant</u>			ADDRESS (Street, city or town, state) <u>5600 N.H.Ave Wash D.C.</u>				
PHYSICIAN'S NAME (Type) <u>Samuel M. Bageant, M. D. 5600 New Hampshire Ave., NE Washington, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hosp. Takoma Park Md</u>			22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Hare, M.D. Wash. San. Hosp.</u>				24a. REC'D BY REGISTRAR <u>24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert G. Hare</u>	

2075252XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HIGHEST SCHOOLING High School		10. RELIGION Methodist	
11. CAUSE OF DEATH Suicide by gunshot		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH April 4, 1968		15. TIME OF DEATH 11:00 AM	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF NEXT OF KIN (None)		18. SIGNATURE OF PHYSICIAN (None)		19. SIGNATURE OF MORTUARY (None)		20. SIGNATURE OF REGISTRAR (None)	

BUREAU V. 1

FEB 04 1968

RECEIVED  
BUREAU  
FEB 04 1968  
FEB 04 1968  
FEB 04 1968

# 1 4 51 I 2 1 44 VS A15 (4) ISM 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 2197 02167 Reg. Dist. No. 215 1 M 51 I 2 1 44 VS A15 (4) ISM 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> <b>COUNTY</b> <b>Washington</b> <b>47X-3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>3 mos. 27 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Francis</b> Last <b>JOHNSON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 November 1908</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>26</b> Hours <b>26</b> Min.		IF UNDER 24 HRS. Months <b>4</b> Days <b>26</b> Hours <b>26</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabel Splicer, G&amp;P Telephone Company</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>District of Columbia</b>			
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Allen Joseph JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>Florence THOMAS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW-II</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>(Wife) Mrs. Mary Elsie JOHNSON (Same As #2)</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>456X</b> <b>Parvulent Pericarditis</b> DUE TO <b>Pneumonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pericarditis Nodosa</b> DUE TO (c) <b>9 mos -</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>6 days</b> <b>9 mos -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>29 October</b> , 19 <b>57</b> , to <b>26 February</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>26 February</b> , 19 <b>58</b> , and that death occurred at <b>10:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>2-27-58</b>							
ACTUAL SIGNATURE <b>T.S. DUNN, JR., LT, MC, USN</b>				PHYSICIAN'S NAME (Type) <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1 March 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Mattingly</b>				24a. REC'D BY REGISTRAR <b>FEB 28 '58</b>			
24b. REGISTRAR'S SIGNATURE <b>R.A. Mattingly</b>							

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. 31

FEB 28 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02168

2198

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5134 Manning Drive</b>		d. STREET ADDRESS <b>5134 Manning Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Pelletreau</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21, 1880</b>		
9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>			
11. BIRTHPLACE (State or foreign country) <b>Patterson, N. Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles O. Pelletreau</b>		14. MOTHER'S MAIDEN NAME <b>Elma A. House</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Miss Helen D. Jones-Same Item #2</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-Vascular Renal Disease</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>360 Diabetes Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 23, 1958</b> , to <b>Feb 1, 1958</b> , that I last saw the deceased alive on <b>Feb 1, 1958</b> , and that death occurred at <b>11:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Sidney C Cousins</b> M.D. <b>3937 Ingomar St NW 2/1/58</b> PHYSICIAN'S NAME (Type) <b>SIDNEY C COUSINS</b> <b>Wash. D.C.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/4/58</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>Feb 6 '58</b>			
24b. REGISTRAR'S SIGNATURE					

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## References

# Monitory

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James C. Follansbee

Miss Helen E. Jones - age 11m 33

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BUREAU V. S.

FEB 5 1953

RECEIVED

Printed by George W. L. ...

Cedar Hill Cemetery



## 2199 CERTIFICATE OF DEATH

02169

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>1 322 Rockville Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Joppy</u>				4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 18, 1958</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>10</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JAMES VERNON HILL</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA DELORES JOPPY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal distress</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/18</u> , 19 <u>58</u> , to <u>2/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>58</u> , and that death occurred at <u>11:25</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas M. Wilson</u>				ADDRESS (Street, city or town, state) <u>2218 Wisconsin Ave, Bethesda, Md</u> DATE SIGNED <u>2/20/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2-21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 3 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074172XVV

CERTIFICATE OF DEATH

Page 1014

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. PLACE OF DEATH [Faint text]		7. DATE OF DEATH [Faint text]		8. TIME OF DEATH [Faint text]		9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]		11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESS [Faint text]		13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF CORONER [Faint text]		15. SIGNATURE OF JURY [Faint text]		16. SIGNATURE OF JUDGE [Faint text]		17. SIGNATURE OF CLERK [Faint text]		18. SIGNATURE OF REGISTRAR [Faint text]		19. SIGNATURE OF [Faint text]		20. SIGNATURE OF [Faint text]		21. SIGNATURE OF [Faint text]		22. SIGNATURE OF [Faint text]		23. SIGNATURE OF [Faint text]		24. SIGNATURE OF [Faint text]		25. SIGNATURE OF [Faint text]		26. SIGNATURE OF [Faint text]		27. SIGNATURE OF [Faint text]		28. SIGNATURE OF [Faint text]		29. SIGNATURE OF [Faint text]		30. SIGNATURE OF [Faint text]		31. SIGNATURE OF [Faint text]		32. SIGNATURE OF [Faint text]		33. SIGNATURE OF [Faint text]		34. SIGNATURE OF [Faint text]		35. SIGNATURE OF [Faint text]		36. SIGNATURE OF [Faint text]		37. SIGNATURE OF [Faint text]		38. SIGNATURE OF [Faint text]		39. SIGNATURE OF [Faint text]		40. SIGNATURE OF [Faint text]		41. SIGNATURE OF [Faint text]		42. SIGNATURE OF [Faint text]		43. SIGNATURE OF [Faint text]		44. SIGNATURE OF [Faint text]		45. SIGNATURE OF [Faint text]		46. SIGNATURE OF [Faint text]		47. SIGNATURE OF [Faint text]		48. SIGNATURE OF [Faint text]		49. SIGNATURE OF [Faint text]		50. SIGNATURE OF [Faint text]		51. SIGNATURE OF [Faint text]		52. SIGNATURE OF [Faint text]		53. SIGNATURE OF [Faint text]		54. SIGNATURE OF [Faint text]		55. SIGNATURE OF [Faint text]		56. SIGNATURE OF [Faint text]		57. SIGNATURE OF [Faint text]		58. SIGNATURE OF [Faint text]		59. SIGNATURE OF [Faint text]		60. SIGNATURE OF [Faint text]		61. SIGNATURE OF [Faint text]		62. SIGNATURE OF [Faint text]		63. SIGNATURE OF [Faint text]		64. SIGNATURE OF [Faint text]		65. SIGNATURE OF [Faint text]		66. SIGNATURE OF [Faint text]		67. SIGNATURE OF [Faint text]		68. SIGNATURE OF [Faint text]		69. SIGNATURE OF [Faint text]		70. SIGNATURE OF [Faint text]		71. SIGNATURE OF [Faint text]		72. SIGNATURE OF [Faint text]		73. SIGNATURE OF [Faint text]		74. SIGNATURE OF [Faint text]		75. SIGNATURE OF [Faint text]		76. SIGNATURE OF [Faint text]		77. SIGNATURE OF [Faint text]		78. SIGNATURE OF [Faint text]		79. SIGNATURE OF [Faint text]		80. SIGNATURE OF [Faint text]		81. SIGNATURE OF [Faint text]		82. SIGNATURE OF [Faint text]		83. SIGNATURE OF [Faint text]		84. SIGNATURE OF [Faint text]		85. SIGNATURE OF [Faint text]		86. SIGNATURE OF [Faint text]		87. SIGNATURE OF [Faint text]		88. SIGNATURE OF [Faint text]		89. SIGNATURE OF [Faint text]		90. SIGNATURE OF [Faint text]		91. SIGNATURE OF [Faint text]		92. SIGNATURE OF [Faint text]		93. SIGNATURE OF [Faint text]		94. SIGNATURE OF [Faint text]		95. SIGNATURE OF [Faint text]		96. SIGNATURE OF [Faint text]		97. SIGNATURE OF [Faint text]		98. SIGNATURE OF [Faint text]		99. SIGNATURE OF [Faint text]		100. SIGNATURE OF [Faint text]	
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BUREAU V. S.

MAR 3 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2200

## CERTIFICATE OF DEATH

02170

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>8 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2514 LINDELL STREET</b>				d. STREET ADDRESS <b>2514 LINDELL STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMIE</b> Middle <b>ETHEL</b> Last <b>KEEBLER</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>19</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/21/47</b>		9. AGE (In years last birthday) yrs. <b>10</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JAMES H. KEEBLER</b>				14. MOTHER'S MAIDEN NAME <b>ELSA G. HAYES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mr. James H. Keebler, 2514 Lindell St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Convulsion (Cruzein's disease)</b> <b>355x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Increased intracranial pressure ?</b> DUE TO (c) <b>Edema enlargement of BRAIN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>19</b>	Day <b>19</b>	Year <b>19 58</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Silver Spring, Md.</b>	(County) (State)
21. I certify that I attended the deceased from <b>6-22</b> , 19 <b>57</b> , to <b>2-19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-18</b> , 19 <b>58</b> , and that death occurred at <b>9:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1944-Seminary Road</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Carolyn S. Pincock</b>				DATE SIGNED <b>1944-Seminary Road</b>			
PHYSICIAN'S NAME (Type) <b>CAROLYN S. PINCOCK</b>				LOCATION (City, town, or county) (State) <b>Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/24/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner S. Humphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

NAME: [Handwritten Name]  
DATE: [Handwritten Date]  
CAUSE OF DEATH: [Handwritten Cause]  
LOCATION: [Handwritten Location]

RECEIVED  
FEB 24 1958  
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2201 CERTIFICATE OF DEATH

02171

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9207 Longbranch Rd</u>				d. STREET ADDRESS <u>19207 Longbranch Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>AITHER D. KEENE</u>				4. DATE OF DEATH Month Day Year <u>Feb 12 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 1 1908</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECTY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>		11. BIRTHPLACE (State or foreign country) <u>N CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ADRIAN DODLEY</u>				14. MOTHER'S MAIDEN NAME <u>ADELAIDE HINES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-206484</u>		17. INFORMANT <u>HUSBAND SAM J.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Mandible with</u> <u>196.1</u> DUE TO <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 19 58</u> to <u>February 19 58</u> , that I last saw the deceased alive on <u>Feb. 12</u> , 19 <u>58</u> , and that death occurred at <u>7:20 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard H Fitzgerald</u> M.D.				ADDRESS (Street, city or town, state) <u>217 University Blvd E SS</u>		DATE SIGNED <u>2/12/58</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD A FITZGERALD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>FEB. 14 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don DeVol</u> ADDRESS <u>2224 WIS AVE WASH DC</u>				24a. REC'D BY REGISTRAR <u>FEB 16 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. J. DeLoach</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MAYNARD		45		M		W		1880		BALTIMORE		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
FEB 18 1953		BALTIMORE		BALTIMORE		MD		USA		FEB 18 1953		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
HEART DISEASE		NATURAL		BALTIMORE		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
FEB 18 1953		BALTIMORE		BALTIMORE		MD		USA		FEB 18 1953		BALTIMORE		BALTIMORE		MD	

BUREAU V. 21

FEB 18 1953

RECEIVED

## 2202 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12910 Colesville Road</u>		d. STREET ADDRESS <u>1 12910 Colesville Road</u>	
3. NAME OF DECEASED (Type or print) First <u>CLELL</u> Middle <u>H.</u> Last <u>KELLER</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1911</u>
9. AGE (In years lost birthday) yrs. <u>46</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Building Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>London County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Delbert M. Keller</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Acku</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578-09-2545</u>	
17. INFORMANT <u>Mrs. Edith B. Keller, (same as #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>26 3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Branchial asthma</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>50</u> , to <u>Feb 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>58</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>8237 Georgia Ave Silver Spring MD 2/10/58</u>	
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>		<u>8237 GA. AVE SILVER SPRING MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 12, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colesville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW DC</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Don't March</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
PLACE OF DEATH		CITY OF DEATH	
MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
AGE		SEX	
35		MALE	
RACE		COLOR OF HAIR	
WHITE		BROWN	
EDUCATION		OCCUPATION	
HIGH SCHOOL		ATTORNEY	
MARRIED		SINGLE	
YES		NO	
NAME OF SPOUSE		NAME OF NEXT OF KIN	
JANET RAY		JAMES EARL RAY	
ADDRESS		CITY AND STATE	
1125 S. GUYTON AVE., MEMPHIS, TENN.		MEMPHIS, TENN.	

CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL CAUSE	
CORONARY ARTERY DISEASE		SUICIDE	
MYOCARDIAL INFARCTION		HOMICIDE	
THROMBOSIS		ACCIDENT	
HYPERTENSION		OTHER	
DIABETES		UNSPECIFIED	
CANCER		OTHER	
TUBERCULOSIS		OTHER	
PNEUMONIA		OTHER	
ASTHMA		OTHER	
EPILEPSY		OTHER	
PSYCHIC DISORDER		OTHER	
ALCOHOLISM		OTHER	
DRUG ABUSE		OTHER	
OTHER		OTHER	

SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE	
APRIL 4, 1968		APRIL 4, 1968	
PLACE		PLACE	
MEMPHIS, TENN.		MEMPHIS, TENN.	
CITY AND STATE		CITY AND STATE	
MEMPHIS, TENN.		MEMPHIS, TENN.	
NAME OF DECEASED		NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
ADDRESS		ADDRESS	
1125 S. GUYTON AVE., MEMPHIS, TENN.		1125 S. GUYTON AVE., MEMPHIS, TENN.	
CITY AND STATE		CITY AND STATE	
MEMPHIS, TENN.		MEMPHIS, TENN.	

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FEB 13 1958

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2203

## CERTIFICATE OF DEATH

02173

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>14521 Bennion Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Francis</u> Last <u>Kelly</u>		4. DATE OF DEATH <u>2</u> Month <u>2</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman, Borden's Milk Co., N.Y.C.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brooklyn, N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Gannon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>09940-6814A</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral confluent Bronchopneumonia pneumonia</u> DUE TO (b) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>26 hours</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 1, 1958</u> , to <u>Feb 2, 1958</u> , that I last saw the deceased alive on <u>Feb 1, 1958</u> , and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herman Maganzini</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd Rockville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>HERMAN MAGANZINI</u>		DATE SIGNED <u>Feb 5 '58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 5 '58</u>	<u>mt Olivet Cem.</u>	<u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Pumpfery</u>		ADDRESS <u>8454 Baltimore Rd. S.B. Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>FEB 5 '58</u>		<u>W. E. Pumpfery</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		HOSPITAL	
DATE OF DEATH		HOURS OF DEATH	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		OCCUPATION	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF WITNESS		SIGNATURE OF DEATH REGISTRAR	

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THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE DEATH REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE CAUSE OF DEATH IS PROPERLY REPORTED. THE DEATH REGISTRAR IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED BY THE PHYSICIAN OR WITNESS.



2204

Items 10b, 16 Film G226 3-3-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P.G.</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avondale</b> 16x. 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>2007 Woodreeve Road</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>William</b> Last <b>KERN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 June 1921</b>	
9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Potomac Elec. Power Co. / Tele. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>George Henry KERN</b>				14. MOTHER'S MAIDEN NAME <b>Pauline Marie SCHORB</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW-II</b>				16. SOCIAL SECURITY NO. <b>579-12-6603</b>		17. INFORMANT <b>(Wife) Mrs. Margaret M. KERN (Same As #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1 Branchogenic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>4 February</b> , 19 <b>58</b> , to <b>20 February</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>20 February</b> , 19 <b>58</b> , and that death occurred at <b>2:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>James E. McClenathan</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md. 2-21-58</b> PHYSICIAN'S NAME (Type) <b>James E. McClenathan, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-25-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE Funeral Home</b>				24a. REC'D BY REGISTRAR <b>FEB 24 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	
25. ADDRESS <b>LEE Funeral Home 4th &amp; Mass. Ave., N.W. Wash. D.C.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

DATE OF BIRTH

PLACE OF BIRTH

AGE

SEX

COLOR

RELIGION

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS MARRIAGES

PREVIOUS DIVORCES

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FEB 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2205 CERTIFICATE OF DEATH

Reg. Dist. No.

02175

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist of Col</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cethesda</u>		c. LENGTH OF STAY IN 1b <u>2 yrs 5 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium &amp; Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5517 Howard St. Washington, D.C.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>Kennedy Warren Apts 47x-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Newton</u> Last <u>Kerr</u>		4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8 Dec 1967</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Dist of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph H. Eaton</u>		14. MOTHER'S MAIDEN NAME <u>Dusan Blaney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>2040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Leukemia Lymphatic</u> DUE TO (c) <u>Scene scene</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-31</u> , 19 <u>50</u> , to <u>2-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-4</u> , 19 <u>58</u> , and that death occurred at <u>2-45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clapham P. King</u> M.D.		ADDRESS (Street, city or town, state) <u>1835 Eye St NW Washington</u>	
PHYSICIAN'S NAME (Type) <u>CLAPHAM P. KING</u>		DATE SIGNED <u>2-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Newlin Sons, Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 6 58</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES EARL RAY		Male		35		April 14, 1928		Memphis, Tennessee		None	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
April 4, 1968		Baltimore, Maryland		Suicide		Suicide		[Signature]		[Signature]	
13. HISTORY OF ILLNESS											
The deceased was in good health until approximately March 1968, when he began to experience depression and loss of interest in life. He had no previous history of mental illness.											
14. MEDICAL HISTORY											
The deceased had no known medical conditions or chronic diseases.											
15. SOCIAL HISTORY											
The deceased was a single man, a member of the Methodist Church, and had no known alcohol or drug abuse.											
16. FAMILY HISTORY											
The deceased had no known family history of mental illness.											
17. PATHOLOGICAL FINDINGS											
Autopsy performed on April 6, 1968. Findings consistent with suicide.											
18. COMMENTS											
The death was certified as suicide by the attending physician and the medical examiner.											

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FEB. 6 1968

RECEIVED

**CERTIFICATE OF DEATH**

Reg. Dist. No.

02176

<p>1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u></p>				<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u></p>				<p>1 d. STREET ADDRESS <u>208 Haines Lane</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Baby Boy Keys</u></p>				<p>4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>1958</u></p>			
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>FEB 24<sup>th</sup> 1958</u></p>	
<p>9. AGE (In years last birthday) <u>6</u> yrs.</p>		<p>IF UNDER 1 YEAR Months <u>6</u> Days <u>30</u></p>		<p>IF UNDER 24 HRS. Hours <u>6</u> Min. <u>30</u></p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>							
<p>13. FATHER'S NAME <u>THOMAS CHANDLER KEYS</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>MILDRED LORRAINE COLEMAN</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <u>NONE</u></p>		<p>17. INFORMANT Address <u>Thomas Keys - Father</u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO</p>							<p>INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>58</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	
				<p>20f. (City or town) _____ (County) _____ (State) _____</p>			
<p>21. I certify that I attended the deceased from <u>2/24</u>, 19<u>58</u>, to <u>2/24</u>, 19<u>58</u>, that I last saw the deceased alive on <u>2/24</u>, 19<u>58</u>, and that death occurred at <u>3:00</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/24/58</u></p>							
<p>ACTUAL SIGNATURE <u>John M. Wyman</u> M.D.</p>							
<p>PHYSICIAN'S NAME (Type) <u>John M Wyman</u></p>				<p><u>7659 Georgetown Rd., Beth., Md.</u></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>3/3/58</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Cumby - Bethesda, Maryland</u></p>				<p>24a. REC'D BY REGISTRAR <u>W. B. Esch</u> DATE <u>FEB 28 '58</u></p>		<p>24b. REGISTRAR'S SIGNATURE</p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 19

FEB 28 1953

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2207 Form 9 Film G225 2-24-58 et  
**CERTIFICATE OF DEATH**

02177

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges County</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4295 Oak Lane Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>John</u> Last <u>King</u>				4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 20 1883</u> 176 yrs.	
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John King</u>				14. MOTHER'S MAIDEN NAME <u>SUSANNAH Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-24-7350</u>		17. INFORMANT <u>Daughter Mrs Cora F. Riskey Capital Hill</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Alcoholism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>22 Jan</u> , 19 <u>58</u> , to <u>13 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>13 Feb</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Herman C. Maganzini</u> M.D. <u>809 Viers Mill Rd.</u> PHYSICIAN'S NAME (Type) <u>Herman C. Maganzini</u> <u>Rockville, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. BARNABAS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>Oxon Hill, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers</u> ADDRESS <u>Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>Feb 18 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER							
RELIGION		METHODIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		BAPTIST		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER					
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH							
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF DECEASED							

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2208 CERTIFICATE OF DEATH

02178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Cedar Grove</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Woodfield</u>		d. STREET ADDRESS <u>R.F.D. Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. Germantown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Avondale</u> Last <u>King</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1878</u>
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cedar Grove, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Noah Watkins</u>		14. MOTHER'S MAIDEN NAME <u>Julia Linthicum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mr. W. O. King, Gaithersburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>15 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 10</u> , 19 <u>47</u> , to <u>Feb. 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>February 14</u> , 19 <u>58</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kerr</u>		ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>		DATE SIGNED <u>2/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 22, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Woodfield, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm L. Moleworth</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Moleworth</u>	





2209 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cedar Grove</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural - Cedar Grove</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. Germantown</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nona</u> Middle <u>Estelle</u> Last <u>King</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1873</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cedar Grove, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Willard Watkins</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mrs Lottie Good, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Cervix, metastatic</u> <u>171x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>13 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized; Secondary anemia; Cong. Ht.F.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		
			20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>		
21. I certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>Feb. 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 1</u> , 19 <u>58</u> , and that death occurred at <u>AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>2/3/58</u> ACTUAL SIGNATURE <u>G. Meadors M.D.</u> PHYSICIAN'S NAME (Type) <u>Gilcin F. Meadors, M.D.</u> <u>Damascus, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Grove, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Moleworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 6 58</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

BUREAU V. S.

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2210 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> <b>2212.2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Alvin</b> Last <b>King</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 16, 1928</b>
9. AGE (In years lost birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Traffic manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John L. King, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Emily Wolfe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW II Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Embryonal cell Carcinoma Primary in Right Testis.</b> DUE TO (c) <b>Metastases to lungs, Right Kidney &amp; Inf. Vena Cava.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 1/4 Yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 4, 1958</b> , to <b>February 8, 1958</b> , that I last saw the deceased alive on <b>February 8, 1958</b> , and that death occurred at <b>11:55AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles F. Nadler</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES F. NADLER M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for recording death statistics, including fields for name, age, sex, race, cause of death, and date of death. The form is partially filled out with handwritten text.

BUREAU V. S.

FEB 11 1958

RECEIVED

Robert A. Humphrey-Medical, Maryland

## 2211 CERTIFICATE OF DEATH

Reg. Dist. No.

02181

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>XAVIERIAN College</u>				d. STREET ADDRESS <u>110.000 New Hampshire Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>John</u> Last <u>Klinger</u> <u>BRO. BENNETT. CEX.</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3-1908</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months <u>44</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>HASTON PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Klinger</u>				14. MOTHER'S MAIDEN NAME <u>MARION Demshock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>College Records</u>		17. INFORMANT <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC Cardiovascular Disease</u> DUE TO (c) <u>1953</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Ingenious</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARKINSONISM</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB. 11, 1958</u> , to <u>FEB. 5, 1958</u> , that I last saw the deceased alive on <u>9/2, 1957</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George P. George</u>				ADDRESS (Street, city or town, state) <u>9404 Colverville Rd S. Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE P. GEORGE</u>				DATE SIGNED <u>Feb 13 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>DAKOTA MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F EVANS &amp; SON</u>				ADDRESS <u>118 W. MT. Royal Ave</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 13 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2212 CERTIFICATE OF DEATH

Reg. Dist. No.

02182

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
c. LENGTH OF STAY IN lb <b>10 yrs.</b>		d. STREET ADDRESS <b>8300 - 16th St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8300 - 16th St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD WILLIAM KOCH</b> Middle Last		4. DATE OF DEATH <b>FEBRUARY 19 19 58</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>DEC. 22, 1863</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Division Chief, retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Warner A. Koch</b>		14. MOTHER'S MAIDEN NAME <b>Adolphine Gruen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Helen L. Koch, 8300 - 16th St., Silver Spring.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cocoonary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 50</b> to <b>Feb. 19</b> , 19 <b>58</b> that I last saw the deceased alive on <b>Feb. 18</b> , 19 <b>58</b> , and that death occurred at <b>7 30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Marion Bankhead</b>		A ADDRESS (Street, city or town, state) <b>9241 Columbia Blvd., Silver Spring</b>	
DATE SIGNED <b>2/19/58</b>			
PHYSICIAN'S NAME (Type) <b>J. Marion Bankhead</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Feb. 22, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, PRINCE GEO. CO., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner B. Humphrey</b>		ADDRESS <b>Silver Spring, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 24 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. B. Humphrey</b>	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED <b>EDWARD W. WARD</b>		2. SEX <b>MALE</b>	
3. AGE <b>30</b>		4. DATE OF BIRTH <b>1912</b>	
5. PLACE OF BIRTH <b>NEW YORK</b>		6. OCCUPATION <b>SALES</b>	
7. MARITAL STATUS <b>MARRIED</b>		8. DATE OF MARRIAGE <b>1935</b>	
9. NAME OF SPOUSE <b>MARY W. WARD</b>		10. PLACE OF MARRIAGE <b>NEW YORK</b>	
11. DATE OF DEATH <b>1942</b>		12. PLACE OF DEATH <b>NEW YORK</b>	
13. CAUSE OF DEATH <b>HEART DISEASE</b>		14. MEDICAL HISTORY <b>None</b>	
15. SIGNATURE OF PHYSICIAN <b>[Signature]</b>		16. SIGNATURE OF DECEASED <b>[Signature]</b>	
17. SIGNATURE OF WITNESS <b>[Signature]</b>		18. SIGNATURE OF DECEASED <b>[Signature]</b>	
19. SIGNATURE OF DECEASED <b>[Signature]</b>		20. SIGNATURE OF DECEASED <b>[Signature]</b>	
21. SIGNATURE OF DECEASED <b>[Signature]</b>		22. SIGNATURE OF DECEASED <b>[Signature]</b>	
23. SIGNATURE OF DECEASED <b>[Signature]</b>		24. SIGNATURE OF DECEASED <b>[Signature]</b>	
25. SIGNATURE OF DECEASED <b>[Signature]</b>		26. SIGNATURE OF DECEASED <b>[Signature]</b>	
27. SIGNATURE OF DECEASED <b>[Signature]</b>		28. SIGNATURE OF DECEASED <b>[Signature]</b>	
29. SIGNATURE OF DECEASED <b>[Signature]</b>		30. SIGNATURE OF DECEASED <b>[Signature]</b>	
31. SIGNATURE OF DECEASED <b>[Signature]</b>		32. SIGNATURE OF DECEASED <b>[Signature]</b>	
33. SIGNATURE OF DECEASED <b>[Signature]</b>		34. SIGNATURE OF DECEASED <b>[Signature]</b>	
35. SIGNATURE OF DECEASED <b>[Signature]</b>		36. SIGNATURE OF DECEASED <b>[Signature]</b>	
37. SIGNATURE OF DECEASED <b>[Signature]</b>		38. SIGNATURE OF DECEASED <b>[Signature]</b>	
39. SIGNATURE OF DECEASED <b>[Signature]</b>		40. SIGNATURE OF DECEASED <b>[Signature]</b>	
41. SIGNATURE OF DECEASED <b>[Signature]</b>		42. SIGNATURE OF DECEASED <b>[Signature]</b>	
43. SIGNATURE OF DECEASED <b>[Signature]</b>		44. SIGNATURE OF DECEASED <b>[Signature]</b>	
45. SIGNATURE OF DECEASED <b>[Signature]</b>		46. SIGNATURE OF DECEASED <b>[Signature]</b>	
47. SIGNATURE OF DECEASED <b>[Signature]</b>		48. SIGNATURE OF DECEASED <b>[Signature]</b>	
49. SIGNATURE OF DECEASED <b>[Signature]</b>		50. SIGNATURE OF DECEASED <b>[Signature]</b>	
51. SIGNATURE OF DECEASED <b>[Signature]</b>		52. SIGNATURE OF DECEASED <b>[Signature]</b>	
53. SIGNATURE OF DECEASED <b>[Signature]</b>		54. SIGNATURE OF DECEASED <b>[Signature]</b>	
55. SIGNATURE OF DECEASED <b>[Signature]</b>		56. SIGNATURE OF DECEASED <b>[Signature]</b>	
57. SIGNATURE OF DECEASED <b>[Signature]</b>		58. SIGNATURE OF DECEASED <b>[Signature]</b>	
59. SIGNATURE OF DECEASED <b>[Signature]</b>		60. SIGNATURE OF DECEASED <b>[Signature]</b>	
61. SIGNATURE OF DECEASED <b>[Signature]</b>		62. SIGNATURE OF DECEASED <b>[Signature]</b>	
63. SIGNATURE OF DECEASED <b>[Signature]</b>		64. SIGNATURE OF DECEASED <b>[Signature]</b>	
65. SIGNATURE OF DECEASED <b>[Signature]</b>		66. SIGNATURE OF DECEASED <b>[Signature]</b>	
67. SIGNATURE OF DECEASED <b>[Signature]</b>		68. SIGNATURE OF DECEASED <b>[Signature]</b>	
69. SIGNATURE OF DECEASED <b>[Signature]</b>		70. SIGNATURE OF DECEASED <b>[Signature]</b>	
71. SIGNATURE OF DECEASED <b>[Signature]</b>		72. SIGNATURE OF DECEASED <b>[Signature]</b>	
73. SIGNATURE OF DECEASED <b>[Signature]</b>		74. SIGNATURE OF DECEASED <b>[Signature]</b>	
75. SIGNATURE OF DECEASED <b>[Signature]</b>		76. SIGNATURE OF DECEASED <b>[Signature]</b>	
77. SIGNATURE OF DECEASED <b>[Signature]</b>		78. SIGNATURE OF DECEASED <b>[Signature]</b>	
79. SIGNATURE OF DECEASED <b>[Signature]</b>		80. SIGNATURE OF DECEASED <b>[Signature]</b>	
81. SIGNATURE OF DECEASED <b>[Signature]</b>		82. SIGNATURE OF DECEASED <b>[Signature]</b>	
83. SIGNATURE OF DECEASED <b>[Signature]</b>		84. SIGNATURE OF DECEASED <b>[Signature]</b>	
85. SIGNATURE OF DECEASED <b>[Signature]</b>		86. SIGNATURE OF DECEASED <b>[Signature]</b>	
87. SIGNATURE OF DECEASED <b>[Signature]</b>		88. SIGNATURE OF DECEASED <b>[Signature]</b>	
89. SIGNATURE OF DECEASED <b>[Signature]</b>		90. SIGNATURE OF DECEASED <b>[Signature]</b>	
91. SIGNATURE OF DECEASED <b>[Signature]</b>		92. SIGNATURE OF DECEASED <b>[Signature]</b>	
93. SIGNATURE OF DECEASED <b>[Signature]</b>		94. SIGNATURE OF DECEASED <b>[Signature]</b>	
95. SIGNATURE OF DECEASED <b>[Signature]</b>		96. SIGNATURE OF DECEASED <b>[Signature]</b>	
97. SIGNATURE OF DECEASED <b>[Signature]</b>		98. SIGNATURE OF DECEASED <b>[Signature]</b>	
99. SIGNATURE OF DECEASED <b>[Signature]</b>		100. SIGNATURE OF DECEASED <b>[Signature]</b>	

BUREAU V. E.

FEB 24 1958

RECEIVED

2213 CERTIFICATE OF DEATH

Reg. Dist. No. 02183

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Browningsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Browningsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. Monrovia</u>				d. STREET ADDRESS <u>R.F.D. Monrovia</u>			
3. NAME OF DECEASED (Type or print) First <u>Forest</u> Middle <u>T.</u> Last <u>Larman</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 20, 1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building Painter</u>			
11. BIRTHPLACE (State or foreign country) <u>Barnesville, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William E. Larman</u>				14. MOTHER'S MAIDEN NAME <u>Catherine R. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-14-7231</u>			
17. INFORMANT <u>Mrs Mildred Larman, Monrovia, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>6 years.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>February</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 12</u> , 19 <u>58</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/21/58</u>							
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.				DATE SIGNED <u>2/21/58</u>			
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>				ADDRESS <u>Int. Airy, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 22, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. McLean</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W.B. Culwell</u>			

BUREAU V. 3

FEB 26 1958

RECEIVED  
FEB 26 1958



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2214 CERTIFICATE OF DEATH

02184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>#10 Farmington Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Willson</u> Last <u>Laskey</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1913</u>		9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Prentiss Willson</u>				14. MOTHER'S MAIDEN NAME <u>Edith Everett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Robert Reeside Chevy Chase, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>Sys.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 15</u> , 19 <u>58</u> , to <u>Feb 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>58</u> , and that death occurred at <u>7:50</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Wilson Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>1629 Columbia Rd. Wash DC</u>			
PHYSICIAN'S NAME (Type) <u>Charles Wilson Jones, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Feb. 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ceder Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Stutland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons, Washington, D.C.</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

FEB 19 1958

RECEIVED

02185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>32 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>c/o Aldo D'Alessandro</b> <b>776 Ripley Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Bronius</b> Last <b>Laucka III</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 19, 1946</b>	
9. AGE (In years last birthday) <b>12</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min. <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph B. Laucka</b>		14. MOTHER'S MAIDEN NAME <b>Isabella A. Mocejunas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-Intestinal hemorrhage with aspiration</b> <b>200.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Reticulum cell sarcoma, metastatic to lungs, pleura, and</b> DUE TO (c) <b>kidneys, intestines, lymph nodes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>15 mos</b> <b>11</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 3, 19 58</b> , to <b>February 4, 19 58</b> , that I last saw the deceased alive on <b>February 4, 19 58</b> , and that death occurred at <b>4:35 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>1/5/58</b> ACTUAL SIGNATURE <b>Theodore Robinson</b> M.D. PHYSICIAN'S NAME (Type) <b>Theodore Robinson, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/8/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>			

VS A15 (4)  
15M 10/57

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

Date of Death February 10, 1958		Place of Death Baltimore, Maryland	
Name of Deceased John E. Lammie		Sex Male	
Date of Birth January 19, 1916		Age 42 years	
Usual Residence 1100 North Avenue, Baltimore, Maryland		Cause of Death Coronary Thrombosis	
Immediate Cause Myocardial Infarction		Contributing Cause Hypertension	
Physician's Signature [Signature]		Medical Examiner's Signature [Signature]	
Date of Report February 10, 1958		Report Made by [Name]	

BUREAU V. S.

FEB 10 1958

RECEIVED

2216

## CERTIFICATE OF DEATH

Reg. Dist. No.

02186

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emory Grove Rural Redland</b>		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammons Rest Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Delaware</b> Middle <b>Lee</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown 1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houseman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lee</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ruby Russell. 732 Hobart Pl. N. W. Wash.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage Pons &amp; Medulla</b> <b>446X</b> DUE TO Cerebral Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Renal Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis Bursitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 22</b> , 19 <b>54</b> , to <b>Feb. 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 7</b> , 19 <b>58</b> , and that death occurred at <b>2:30 A.</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Norbeck, RFD Silver Spring, Md.</b>	
ACTUAL SIGNATURE <b>Robert L. Snowden</b> M.D.		DATE <b>2/9/58</b>	
PHYSICIAN'S NAME (Type) <b>Webster Sewell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/12/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>First Baptist Church.,</b>	22d. LOCATION (City, town, or county) (State) <b>Falls Church, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		24a. REC'D BY REGISTRAR <b>Feb 14 '58</b>	
ADDRESS <b>Rockville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

2918

Page 1 of 1

1. NAME OF DECEASED J. M. JONES		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1893	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Teacher	
7. MARITAL STATUS Married		8. DATE OF DEATH Feb 14 1958	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease	
11. MEDICAL HISTORY Hypertension, Atherosclerosis		12. SIGNATURE OF PHYSICIAN J. M. Smith, M.D.	
13. SIGNATURE OF REGISTRAR J. M. Jones		14. SIGNATURE OF WITNESSES J. M. Jones, J. M. Jones	
15. SIGNATURE OF FUNERAL HOME J. M. Jones		16. SIGNATURE OF BURIAL PLACE J. M. Jones	
17. SIGNATURE OF COUNTY CLERK J. M. Jones		18. SIGNATURE OF STATE CLERK J. M. Jones	

RECEIVED

FEB 14 1958

BUREAU V. S.

2108

## CERTIFICATE OF DEATH

02187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oakhaven Rest Home</b>		d. STREET ADDRESS <b>9200 River Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>LEE</b> Last <b>Leonard</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>25</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/7/72</b>
9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>18</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Warren</b>		14. MOTHER'S MAIDEN NAME <b>Annie Duncan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John C. Leonard-Item# 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Testicular lymphoma + fibrosarcoma</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anterior heart dis. coronary artery of</b> DUE TO (c) <b>Anterior</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Broken vessels - fill on one</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b></b> o. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/13/1958</b> to <b>2/23/1958</b> , that I last saw the deceased alive on <b>2/23/58</b> , 19 <b>58</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>500 Underwood St NW Wash DC</b> DATE SIGNED <b>CHN</b>			
ACTUAL SIGNATURE <b>CHN</b>		M.D. <b>Wash DC</b>	
PHYSICIAN'S NAME (Type) <b>CHAS H WOLOHAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/27/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 27 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

FEB 27 1958

RECEIVED  
FEB 27 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2109 CERTIFICATE OF DEATH

Reg. Dist. No. 02188

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Stewart</u> Last <u>Lester</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>11</u> - Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-78</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher (College Professor)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Miss.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.G.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>	
13. FATHER'S NAME <u>William J. Lester</u>				14. MOTHER'S MAIDEN NAME <u>Savella Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Washington Sanitarium Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Valvular Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Jan 23, 1958</u> , to <u>Feb 11, 1958</u> , that I last saw the deceased alive on <u>Feb 11, 1958</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip E. Jones</u>		M.D. <u>918 Ellsworth Drive</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>2-11-58</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP E. JONES</u>		<u>Silver Spring Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>FEB 13 '58</u>		<u>W. E. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2217 CERTIFICATE OF DEATH

02189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cherry Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GENEVIEVE LEMEN Lyford</b>		4. DATE OF DEATH <b>2 5 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18 1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State College</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert E. Lyford</b>		14. MOTHER'S MAIDEN NAME <b>Clara Burgh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Brother - Harry B. Lyford</b>	
17. INFORMANT <b>Brother - Harry B. Lyford</b>		Address <b>7306 Delfield St. Cherry Chase</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio vascular renal disease</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Extensive herpes zoster involving left supra orbital nerve</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 25, 1957</b> , to <b>Feb 5, 1958</b> , that I last saw the deceased alive on <b>Feb 3, 1958</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Duane C. Richtmeyer M.D.</b>		ADDRESS (Street, city or town, state) <b>1235 Eye St. NW</b> DATE SIGNED <b>2-5-58</b>	
PHYSICIAN'S NAME (Type) <b>DUANE C. RICHTMEYER</b>		<b>Washington 4, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>2/6/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Quinn</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 100

2000

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF NEXT OF KIN</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF NEXT OF KIN</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF NEXT OF KIN</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF NEXT OF KIN</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF NEXT OF KIN</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF NEXT OF KIN</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF NEXT OF KIN</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF NEXT OF KIN</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF NEXT OF KIN</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF NEXT OF KIN</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF NEXT OF KIN</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF NEXT OF KIN</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF NEXT OF KIN</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF NEXT OF KIN</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF NEXT OF KIN</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF NEXT OF KIN</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF NEXT OF KIN</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF NEXT OF KIN</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF NEXT OF KIN</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF NEXT OF KIN</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF NEXT OF KIN</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF NEXT OF KIN</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF NEXT OF KIN</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF NEXT OF KIN</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF NEXT OF KIN</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF NEXT OF KIN</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF NEXT OF KIN</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF NEXT OF KIN</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF NEXT OF KIN</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF NEXT OF KIN</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF NEXT OF KIN</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF NEXT OF KIN</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF NEXT OF KIN</p>		<p>84. SIGNATURE OF DECEASED</p>		<p>85. SIGNATURE OF NEXT OF KIN</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF NEXT OF KIN</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF NEXT OF KIN</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF NEXT OF KIN</p>		<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF NEXT OF KIN</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF NEXT OF KIN</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF NEXT OF KIN</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF NEXT OF KIN</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. S.

FEB 10 1958

RECEIVED

## 2218 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> hrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>Rt. 2 Box 250.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman Clinton Lynch</u>				4. DATE OF DEATH Month Day Year <u>2 - 21 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1896</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Lynch</u>				14. MOTHER'S MAIDEN NAME <u>Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army WW I</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>578-09-0845</u>		17. INFORMANT <u>Sister Elsie G. Pond</u> Address <u>200 Lawrence St. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Acute myocardial Infarction</u> (c) <u>Coronary Insufficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June, 1946</u> to <u>Feb 21, 1958</u> , that I last saw the deceased alive on <u>Feb 21, 1958</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4709 Montgomery Lane Bethesda, Md.</u> DATE SIGNED <u>Feb 26 1958</u>							
ACTUAL SIGNATURE <u>Paul J. Cantow</u> M.D.				PHYSICIAN'S NAME (Type) <u>Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 26, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clin L. Molesworth</u> ADDRESS <u>Damascus Md</u>				24a. REC'D BY REGISTRAR <u>Feb 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Rehman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CEMETERY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF CLERGY		21. SIGNATURE OF OTHERS	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF NEXT OF KIN		24. SIGNATURE OF BURIAL OFFICIAL	
25. SIGNATURE OF FUNERAL HOME		26. SIGNATURE OF CEMETERY		27. SIGNATURE OF CHURCH	
28. SIGNATURE OF MINISTERS		29. SIGNATURE OF CLERGY		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF BURIAL OFFICIAL	
34. SIGNATURE OF FUNERAL HOME		35. SIGNATURE OF CEMETERY		36. SIGNATURE OF CHURCH	
37. SIGNATURE OF MINISTERS		38. SIGNATURE OF CLERGY		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF NEXT OF KIN		42. SIGNATURE OF BURIAL OFFICIAL	
43. SIGNATURE OF FUNERAL HOME		44. SIGNATURE OF CEMETERY		45. SIGNATURE OF CHURCH	
46. SIGNATURE OF MINISTERS		47. SIGNATURE OF CLERGY		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF BURIAL OFFICIAL	
52. SIGNATURE OF FUNERAL HOME		53. SIGNATURE OF CEMETERY		54. SIGNATURE OF CHURCH	
55. SIGNATURE OF MINISTERS		56. SIGNATURE OF CLERGY		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF NEXT OF KIN		60. SIGNATURE OF BURIAL OFFICIAL	
61. SIGNATURE OF FUNERAL HOME		62. SIGNATURE OF CEMETERY		63. SIGNATURE OF CHURCH	
64. SIGNATURE OF MINISTERS		65. SIGNATURE OF CLERGY		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF NEXT OF KIN		69. SIGNATURE OF BURIAL OFFICIAL	
70. SIGNATURE OF FUNERAL HOME		71. SIGNATURE OF CEMETERY		72. SIGNATURE OF CHURCH	
73. SIGNATURE OF MINISTERS		74. SIGNATURE OF CLERGY		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF BURIAL OFFICIAL	
79. SIGNATURE OF FUNERAL HOME		80. SIGNATURE OF CEMETERY		81. SIGNATURE OF CHURCH	
82. SIGNATURE OF MINISTERS		83. SIGNATURE OF CLERGY		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF BURIAL OFFICIAL	
88. SIGNATURE OF FUNERAL HOME		89. SIGNATURE OF CEMETERY		90. SIGNATURE OF CHURCH	
91. SIGNATURE OF MINISTERS		92. SIGNATURE OF CLERGY		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF NEXT OF KIN		96. SIGNATURE OF BURIAL OFFICIAL	
97. SIGNATURE OF FUNERAL HOME		98. SIGNATURE OF CEMETERY		99. SIGNATURE OF CHURCH	
100. SIGNATURE OF MINISTERS		101. SIGNATURE OF CLERGY		102. SIGNATURE OF OTHERS	

RECEIVED  
FEB 26 1938  
BUREAU V. S.

CERTIFICATE OF DEATH

2219

CERTIFICATE OF DEATH

02191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Alabama</b>		b. COUNTY <b>40X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <b>February</b>		Day <b>24,</b>		Year <b>19 58</b>			
3. NAME OF DECEASED (Type or print) First <b>David</b>		Middle <b>Eugene</b>		Last <b>Macon</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 23, 1941</b>		9. AGE (In years last birthday) <b>16</b> yrs.		IF UNDER 1 YEAR Months <b>16</b>		IF UNDER 24 HRS. Days <b>16</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Clarence D. Macon</b>				14. MOTHER'S MAIDEN NAME <b>Bertie Mae Wade</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.6 VENTRICULAR fibrillation</b> DUE TO <b>CONGENITAL Aortic Stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CONGENITAL</b> DUE TO (c) <b>CONGENITAL</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Pulmonary Edema</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bethesda</b>		(County) <b>Montgomery</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>February 9, 19 58</b> , to <b>February 24, 19 58</b> , that I last saw the deceased alive on <b>February 24, 19 58</b> and that death occurred at <b>3:00AM</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Carlos R. Lombardo</b>		M.D. <b>The Clinical Center</b>		ADDRESS (Street, city or town, state) <b>The National Institutes of Health</b>				DATE SIGNED <b>2/24/58</b>			
PHYSICIAN'S NAME (Type) <b>Carlos R. Lombardo, M. D.</b>		<b>Bethesda 14, Maryland</b>									
22a. BURIAL, CREMATION, REMOVAL <b>removal</b>		22b. DATE THEREOF <b>2/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>--</b>		22d. LOCATION (City, town, or county) <b>Jasper, Alabama</b>		(State) <b>Alabama</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co.-2901 14th St.; N.W.</b>				ADDRESS <b>Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>FEB 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to blurriness.

BUREAU V. 1

FEB 25 1959

RECEIVED

Vertical text on the right margin, likely a filing or processing stamp, containing the words "RECEIVED" and "FEB 25 1959".

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2220

## CERTIFICATE OF DEATH

Reg. Dist. No.

02192

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>56</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9707 Bristol Avenue</b>		d. STREET ADDRESS <b>9707 Bristol Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Main</b> Last <b>Main</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/14/1885</b>
9. AGE (In years birth day) yrs. <b>72</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>2</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Main</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Flynn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-03-0690</b>	
17. INFORMANT <b>John G. Main</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Inter-arteriosclerotic Heart Disease</b> DUE TO (c) <b>Basilar</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Cerebral Vascular Accident</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 19, 1958</b> , to <b>February 23, 1958</b> , that I last saw the deceased alive on <b>Feb 22</b> , 1958, and that death occurred at <b>1:40</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard A. Fitzgerald</b> M.D.		ADDRESS (Street, city or town, state) <b>217 University Blvd E</b> DATE SIGNED <b>2/23/58</b>	
PHYSICIAN'S NAME (Type) <b>Bernard A. Fitzgerald</b>		<b>Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>2/25/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 10

BUREAU V. 1

FEB 25 1958

RECEIVED

## 2221 CERTIFICATE OF DEATH

02193

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>18 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>3624 - SAUL Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>H.</u> Last <u>MARLOW</u>				4. DATE OF DEATH 2 - 6 - 58 Year 1958			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 9 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>2</u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTH PLACE (State or foreign country) <u>Philadelphia, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Samuel Neely</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daughter Mrs Janet D. Kensington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured Aneurysm, abdominal Aorta</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Focal myocardial infarctions</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 19</u> , 19 <u>54</u> to <u>Feb. 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 5</u> , 19 <u>58</u> , and that death occurred at <u>7:50 A.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u>				DATE SIGNED <u>2/6/58</u>			
ACTUAL SIGNATURE <u>J. Marion Bankhead</u> M.D.							
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>				<u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albrecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

Wright, Nell

W/O

X

Wright, Nell  
Daughter of W/O Wright  
Born 10/12/1901  
Died 10/12/1901  
Cause of Death: ...

BUREAU V. S.

FEB 10 1958

RECEIVED



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02194

2127

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>approx. 4yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1325 Grandin Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lorraine Barto MARZO</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/23/1918</b>
9. AGE (in years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
13. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>Unknown</b>		16. MOTHER'S MAIDEN NAME <b>Unknown</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>Unknown</b>	
19. INFORMANT <b>Montg. Co. Police Dept.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Alcohol &amp; Carbon monoxide poisoning</b> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Found dead in her home which was afire</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>10:30 P.M. 2/12 1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Rockville Montg. Maryland</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>February 13, 1958</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	22b. DATE THEREOF <b>2/13/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>	22d. LOCATION (City, town, or county) (State) <b>Pleasantville, New Jersey</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>FEB 18 '58</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT

Form with various fields for medical examination and death certificate, including sections for cause of death, manner of death, and examiner's signature.

RECEIVED  
FEB 18 1958  
BUREAU V. 21

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02195**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery County</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington San. + Hosp.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Mont. Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b> d. STREET ADDRESS <b>1752 Silver Spring Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mark Harry</b>		First <b>Mark</b> Middle <b>Harry</b> Last <b>Fuller Massey</b>		<b>4. DATE OF DEATH</b> Month <b>2</b> Day <b>8</b> Year <b>1958</b>									
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10-16-1889</b>	<b>9. AGE</b> (In years last birthday) <b>68</b> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>mechanical eng.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Government</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Kansas</b>									
<b>13. FATHER'S NAME</b> <b>Unknown Massey</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>unknown</b>										
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>560-01-4999</b>		<b>17. INFORMANT</b> <b>Mrs. Dorothy W. Massey, 752 Silver Spring Ave.</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Coronary occlusion</b>  <b>420.1</b> DUE TO             </td> <td rowspan="3" style="vertical-align: top;"> <b>18b. ONSET AND DEATH</b>  <b>sudden</b> </td> </tr> <tr> <td colspan="2"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> </tr> <tr> <td colspan="2"> <b>DUE TO (b)</b>  <b>DUE TO (c)</b> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary occlusion</b> <b>420.1</b> DUE TO		<b>18b. ONSET AND DEATH</b> <b>sudden</b>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>DUE TO (b)</b> <b>DUE TO (c)</b>		
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary occlusion</b> <b>420.1</b> DUE TO		<b>18b. ONSET AND DEATH</b> <b>sudden</b>											
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>													
<b>DUE TO (b)</b> <b>DUE TO (c)</b>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>									
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
<b>ACTUAL SIGNATURE</b> <b>Frank J. Broschant</b> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <b>FRANK J. Broschant</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>2/11/58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>CEDAR HILL CEMETERY</b>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Warner E. Pumphrey</b>		<b>ADDRESS</b> <b>SILVER SPRING, MD.</b>		<b>22d. LOCATION (City, town, or county)</b> <b>(State)</b> <b>PRINCE GEO. COUNTY, MD.</b>									
<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>FEB 11 '58</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <b>W. E. Pumphrey</b>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

FILE NO. 100

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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BUREAU V. S.

FEB 11 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02196

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5416 Huntington Parkway</b>		d. STREET ADDRESS <b>5416 Huntington Parkway</b>	
3. NAME OF DECEASED (Type or print) <b>RICHARD B. McENTIRE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/35</b> 2-19-11 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Geo. Ted. P. McEntire</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Brooke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Esther S. McEntire</b>	
17. INFORMANT <b>same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>February 18, 1958</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	22b. DATE THEREOF <b>2/20/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Shawnee Co. Kansas</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>			



RECEIVED

FEB 04 1953

BUREAU V. S.

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THE  
OFFICE OF  
THE  
ATTORNEY  
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FEB 10 1953

## 2223 CERTIFICATE OF DEATH

Reg. Dist. No.

02197

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>22 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elwood</b> Middle <b>Rodger</b> Last <b>McNutt, Jr.</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 22, 1930</b>		9. AGE (In years last birthday) <b>27</b> yrs.	IF UNDER 1 YEAR Months <b>27</b> Days <b>16</b> Hours <b>15</b> Min. <b>2</b>	IF UNDER 24 HRS. Hours <b>15</b> Min. <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Elwood R. McNutt, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Myrtle Ryan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Korean</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage (massive)</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the colon with metastases</b> DUE TO (c) <b>Ulcerative colitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>3 mos</b> <b>21 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>042.0 Salmonellosis, hematogenous</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 29, 1958</b> , to <b>February 20, 1958</b> , that I last saw the deceased alive on <b>February 20, 1958</b> , and that death occurred at <b>11:35 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald M. Watkin</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>2/21/58</b>	
PHYSICIAN'S NAME (Type) <b>Donald M. Watkin, M. D.</b>				<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 2/21/57</b>		22b. DATE THEREOF <b>2/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>New Kensington, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. Search</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF REGISTRAR	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF MEDICAL OFFICER	
13. SIGNATURE OF CLERGYMAN		14. SIGNATURE OF BURIAL OFFICER		15. SIGNATURE OF FUNERAL HOME	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF TOWN CLERK	
22. SIGNATURE OF VOTING CLERK		23. SIGNATURE OF SCHOOL CLERK		24. SIGNATURE OF CHURCH CLERK	
25. SIGNATURE OF POST OFFICE CLERK		26. SIGNATURE OF RAILROAD CLERK		27. SIGNATURE OF AIRLINE CLERK	
28. SIGNATURE OF MARINE CLERK		29. SIGNATURE OF NAVY CLERK		30. SIGNATURE OF ARMY CLERK	
31. SIGNATURE OF AIR FORCE CLERK		32. SIGNATURE OF SPACE CLERK		33. SIGNATURE OF OTHER CLERK	

RECEIVED  
FEB 24 1958  
BUREAU V. E.

2224 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6005 Ryland Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Mary</b> Last <b>Menkert</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/7/79</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>25</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coffee &amp; Tea</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Conrad C. Eber</b>	
14. MOTHER'S MAIDEN NAME <b>Sophia Aigler</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Edna Holloran, sister</b> Address <b>same as 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion with Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Essential Hypertension</b> (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/1/54</b> 19 to <b>2/2/58</b> 19, that I last saw the deceased alive on <b>2/2/58</b> 19, and that death occurred at <b>5:15 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md</b> DATE SIGNED <b>2/2/58</b>	
PHYSICIAN'S NAME (Type) <b>John J. Curry</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b> DATE <b>FEB 5 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 8

FEB 5 1958

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## 2111 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Prince George's Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp.</u>				d. STREET ADDRESS <u>2010 Drexel St</u>			
3. NAME OF DECEASED (Type or print) <u>John M. Shaw</u>				4. DATE OF DEATH Month <u>2</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-10</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver for Bakery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Thomas Meushaw</u>				14. MOTHER'S MAIDEN NAME <u>Edith Dingee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>  </u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Artery Heart Disease</u> DUE TO <u>2 1/2 yrs</u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>few seconds</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> 19 <u>Feb 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>57</u> , and that death occurred at <u>7:05 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Grey</u> M.D.				DATE SIGNED <u>7/05</u> <u>Regina Rd Adelphi Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Grey</u>				ADDRESS (Street, city or town, state) <u>Washington San Hosp.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-19-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Lee &amp; Sons</u>				ADDRESS <u>300 1/2 St N.E.</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>FEB 21 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. DATE OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESSES

Respectfully reported  
Gervase Henry Jones

True

RECEIVED  
FEB 21 1958  
BUREAU V. E.

1958  
Feb 21  
1102  
1000

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

2225

02200

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montg</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>			c. LENGTH OF STAY IN 1b <u>3 Da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montg. Co. General Hosp.</u>				d. STREET ADDRESS <u>7-Russel Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Anne</u> Middle <u>Irene</u> Last <u>Meyer</u>				<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>16</u> Year <u>19 58</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6th 1920</u>		
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeping</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home work</u>		11. BIRTHPLACE (State or foreign country) <u>Newport News, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Henry L. Meyer</u>				14. MOTHER'S MAIDEN NAME <u>Anne Georgia Kuhule</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry L. Meyer, Gaithersburg, Md.</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>NEPHROSCLEROSIS</u> DUE TO (c) <u>ACUTE RENAL FAILURE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>  <u>15 YRS.</u>  <u>48 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>13 Feb, 1958</u> , to <u>16 Feb, 1958</u> , that I last saw the deceased alive on <u>15 Feb, 1958</u> , and that death occurred at <u>3:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>26 N. SUMMIT AVE</u> DATE SIGNED <u>17 Feb 1958</u> ACTUAL SIGNATURE <u>Gordon S. Rosenberg M.D.</u> PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberg</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2112 CERTIFICATE OF DEATH

02201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Infant Girl Miller</u>				4. DATE OF DEATH <u>February 16, 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 16, 1958</u>	
9. AGE (In years lost birthday) yrs. <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert David Miller</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Jane Eilers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>762.5</u>		17. INFORMANT <u>Francis J. Troendle</u> Address <u>809 Viers Mill Road, Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO <u>ATELECTASIS OF LUNGS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 hrs</u> (c) <u>5 hrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>17 Feb 58</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>16 Feb 1958</u> , to <u>16 Feb 1958</u> , that I last saw the deceased alive on <u>16 Feb 1958</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis J. Troendle</u>				ADDRESS (Street, city or town, state) <u>809 Viers Mill Road, Rockville, Md.</u>			
DATE SIGNED <u>17 Feb 58</u>							
PHYSICIAN'S NAME (Type) <u>Francis J. Troendle, M.D., 809 Viers Mill Road, Rockville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hosp. Washington Sanitarium and Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Hare, M.D. Washington Sanitarium and Hospital</u>				24a. REC'D BY REGISTRAR <u>W. Beach</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	
DATE <u>FEB 24 '58</u>							



BUREAU

FEB 24 1958

RECEIVED

2226 CERTIFICATE OF DEATH

Reg. Dist. No.

02202

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1911 ROOKWOOD ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>ANNA</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>13</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/11/94</b>		9. AGE (In years last birthday) yrs. <b>63</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PENNSYLVANIA</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ALBERT F. GRAFF</b>				14. MOTHER'S MAIDEN NAME <b>JULIA UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mr. Harry L. Miller, Jr., 1911 Rookwood Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PANCREAS</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X DIABETES MELLITUS</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>SEPT. 1954</b> to <b>FEB. 13, 1958</b> , that I last saw the deceased alive on <b>FEB. 12, 1958</b> , and that death occurred at <b>8A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9013 FLOWER AVE. SILVER SPRING, MD.</b> DATE SIGNED <b>4/13/58</b> ACTUAL SIGNATURE <b>L.B. Snow</b> M.D. PHYSICIAN'S NAME (Type) <b>L. B. SNOW</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>2/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Humphrey</b>				24a. REC'D BY REGISTRAR <b>FEB 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Humphrey</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED		SEPARATED		OTHER	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		APRIL 4, 1968		MEMPHIS, TENN.		SHOOTING		HOMICIDE		CIVILIAN		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED			
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 31

FEB 18 1968

RECEIVED

Item 9 FilmG225 2-24-58 et  
2227 CERTIFICATE OF DEATH

02203

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b> <b>08X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>O'Neal</b> Last <b>MOOSE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 January 1910</b>
9. AGE (In years last birthday) <b>48 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps (Retired)</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Edgar MOOSE</b>		14. MOTHER'S MAIDEN NAME <b>Cardilia White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes 3-13-31 to 11-9-37</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Wife) Sarah Creola Moose (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Unkown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 December 19 57</b> to <b>16 February 19 58</b> , that I last saw the deceased alive on <b>15 December 19 58</b> , and that death occurred at <b>10:45A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jerome A. Gold</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>	
DATE SIGNED <b>2-17-58</b>			
PHYSICIAN'S NAME (Type) <b>Jerome A. Gold, LT, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-20-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt &amp; Ryan Funeral Home, Waldorf, Maryland</b>		24a. REC'D. BY REGISTRAR <b>FEB 19 58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W. E. ...</b>	

Hunt & Ryan Funeral Home

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CERTIFICATE OF DEATH

RECEIVED  
FEB 19 1939  
BUREAU V. 3



## 2228 CERTIFICATE OF DEATH

112204

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>9041 Manchester Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Boy</u> Middle <u>MORRIS</u> Last <u>MORRIS</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15 1958</u>
9. AGE (In years last birthday) yrs. <u>5</u>		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur C. Morris</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Fink</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 15</u> , 19 <u>58</u> , to <u>Feb 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>58</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michael L Buckley</u> M.D.		ADDRESS (Street, city or town, state) <u>4636 MONTGOMERY AVE. BETHESDA</u>	
PHYSICIAN'S NAME (Type) <u>MICHAEL L BUCKLEY</u>		DATE SIGNED <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2-21-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>MAR 3 '58</u>		<u>—</u>	

2074362XVV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the paper is devoted to the study of the properties of the function  $f(x)$  defined by the equation

10-10000-01

BUREAU V. S.

MAR 3 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2229

## CERTIFICATE OF DEATH

## 02205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>3407 43rd Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Gilbert</b> Middle <b>Thomas</b> Last <b>Morrison, Jr.</b>				4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1947</b>		9. AGE (In years last birthday) <b>11</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gilbert T. Morrison, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Mable Costlow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemic Embolism, Hemorrhoidosis</b> <b>289.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 8, 1958</b> to <b>February 10, 1958</b> , that I last saw the deceased alive on <b>February 10, 1958</b> , and that death occurred at <b>1:35 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles B. Neal</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
DATE SIGNED <b>2/10/58</b>							
PHYSICIAN'S NAME (Type) <b>Charles B. Neal, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be filed with the funeral director, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 212206

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>63 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMHC, Bethesda Md.</b>		d. STREET ADDRESS <b>2825 Overland Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Herbert Franklin MOSELEY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1958</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 January 1888</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Allan MOSELEY</b>		14. MOTHER'S MAIDEN NAME <b>Lillian REEVES</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I and WW2 unknown</b>		17. INFORMANT Address <b>(Wife) Mrs Virginia May Moseley (Same as #2)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>generalized metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>adenocarcinoma - head of pancreas</b> DUE TO (c) <b>5 months</b>		INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1 December</b> , 19 <b>57</b> , to <b>2 February</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2 February</b> , 19 <b>58</b> , and that death occurred at <b>12:50P</b> M, from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b>		DATE SIGNED <b>2-4-58</b>					
ACTUAL SIGNATURE <b>Bruce H. Rice</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>							
PHYSICIAN'S NAME (Type) <b>Bruce H. Rice, LT, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>							
22a. REMOVAL, CREMATION, BURIAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		ADDRESS <b>1400 Chapin St. Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Reed</b>			



CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. S.

FEB 6 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2113 CERTIFICATE OF DEATH

02207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium &amp; Hospital</b>		e. STREET ADDRESS <b>1915 Glen Ross Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>A.</b> Last <b>Nelson</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/31/1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired -- U.S. Government - Census Bureau</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Edgar A. Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Aureilla Freeman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Robert E. Phelps - 3707 Leland Street</b>	
17. INFORMANT <b>Chevy Chase, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.0</b> (b) <b>—</b> (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 12, 1958</b> to <b>Feb. 15, 1958</b> , that I last saw the deceased alive on <b>Feb. 15, 1958</b> , and that death occurred at <b>10:15</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Marion Bankhead</b>		DATE SIGNED <b>2/14/58</b>	
PHYSICIAN'S NAME (Type) <b>J. Marion Bankhead</b>		ADDRESS (Street, city or town, state) <b>9241 Col. Blvd. Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/19/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24. REC'D BY REGISTRAR <b>Feb 19 1958</b>	
ADDRESS <b>Wash. D.C. 2901 14th St., N.W.</b>		25. REGISTRAR'S SIGNATURE <b>W. E. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White	
DATE OF DEATH Feb 18 1919		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION Clerk		EDUCATION High School	
BIRTH DATE Jan 1 1874		BIRTH PLACE Maryland		MARRIAGE DATE Mar 15 1905		MARRIAGE PLACE Baltimore	
FATHER'S NAME John Harris		MOTHER'S NAME Mary Harris		FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker	
FATHER'S BIRTH DATE Jan 1 1845		MOTHER'S BIRTH DATE Jan 1 1850		FATHER'S BIRTH PLACE Maryland		MOTHER'S BIRTH PLACE Maryland	

RECEIVED  
FEB 18 1919  
BUREAU V. S.

2231

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>New Bern</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Bern</u> 70X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>714 Broad Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Land</u> Last <u>NELSON</u>		4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u>
9. AGE (In years last birthday) <u>66</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u>	11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas A. Land</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Brinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Son-in-law Robert W. Brown</u>		Address <u>920 Gardiner Ave Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Coronary artery occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>12 hours</u> <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5:24h</u> , 19 <u>58</u> , to <u>6:24h</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6:24h</u> , 19 <u>58</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Seruch T. Kimble</u>		M.D. <u>929 Pershing Drive, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>		<u>929 Pershing Drive S. S.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u>	22d. LOCATION (City, town, or county) (State) <u>New Bern, North Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>FEB 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>Quail</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  2. SEX                  3. AGE                  4. DATE OF BIRTH                  5. PLACE OF BIRTH                  6. OCCUPATION                  7. MARITAL STATUS                  8. COLOR                  9. RELIGION                  10. EDUCATION                  11. SOCIAL CLASS                  12. PLACE OF DEATH                  13. DATE OF DEATH                  14. TIME OF DEATH                  15. CAUSE OF DEATH                  16. MANNER OF DEATH                  17. PLACE OF BURIAL                  18. DATE OF BURIAL                  19. NAME OF BURIAL PLACE                  20. NAME OF MINISTER                  21. NAME OF FUNERAL HOME                  22. NAME OF CARRIER                  23. NAME OF COFFIN                  24. NAME OF CASKET                  25. NAME OF CASKET LINER                  26. NAME OF CASKET LID                  27. NAME OF CASKET LID LINER                  28. NAME OF CASKET LID LINER LINER                  29. NAME OF CASKET LID LINER LINER LINER                  30. NAME OF CASKET LID LINER LINER LINER LINER</p>		<p>1. NAME OF DECEASED                  2. SEX                  3. AGE                  4. DATE OF BIRTH                  5. PLACE OF BIRTH                  6. OCCUPATION                  7. MARITAL STATUS                  8. COLOR                  9. RELIGION                  10. EDUCATION                  11. SOCIAL CLASS                  12. PLACE OF DEATH                  13. DATE OF DEATH                  14. TIME OF DEATH                  15. CAUSE OF DEATH                  16. MANNER OF DEATH                  17. PLACE OF BURIAL                  18. DATE OF BURIAL                  19. NAME OF BURIAL PLACE                  20. NAME OF MINISTER                  21. NAME OF FUNERAL HOME                  22. NAME OF CARRIER                  23. NAME OF COFFIN                  24. NAME OF CASKET                  25. NAME OF CASKET LINER                  26. NAME OF CASKET LID                  27. NAME OF CASKET LID LINER                  28. NAME OF CASKET LID LINER LINER                  29. NAME OF CASKET LID LINER LINER LINER                  30. NAME OF CASKET LID LINER LINER LINER LINER</p>
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BUREAU V. S.

FEB 10 1958

RECEIVED



## 2232 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Echo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clara Barton House, Oxford St</u>				d. STREET ADDRESS <u>Oxford Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Eloise</u> Last <u>Noyes</u>				4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/11/1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gott-Dept of Agric.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food manager</u>		11. BIRTHPLACE (State or foreign country) <u>Wyoming, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Sylvester George Franks</u>				14. MOTHER'S MAIDEN NAME <u>Huldah Jane Lytton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-03-6134</u>		17. INFORMANT <u>Mrs. Katharine Bronson</u> Address <u>same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 25, 1957</u> to <u>February 27, 1958</u> that I last saw the deceased alive on <u>February 27, 1958</u> , and that death occurred at <u>4:05 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alban W. Eger</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 1801 Eye St. N.W., Wash, D.C. 2/27/58</u>					
PHYSICIAN'S NAME (Type) <u>ALBAN W. EGER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>3/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wyoming Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wyoming, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 3 1958

BUREAU V. S.

BOND

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2114 CERTIFICATE OF DEATH

02210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTG</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>		d. STREET ADDRESS <u>1905 DAVIS AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>WAYNE</u> Last <u>OLSON</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 14, 1958</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>8</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>TAKOMA PARK, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID JACK OLSON</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES AMELIA RUSSELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <u>DAVID JACK OLSON</u>		Address <u>905 DAVIS AVE., TAKOMA PARK, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-14, 1958</u> , to <u>2-15, 1958</u> , that I last saw the deceased alive on <u>2-15, 1958</u> , and that death occurred at <u>3:08 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert D. Glick</u>		ADDRESS (Street, city or town, state) <u>8301 Piney Br Rd - S.W. Spr, Md</u>	
DATE SIGNED <u>Feb 16 1958</u>			
PHYSICIAN'S NAME (Type) <u>Herbert D. Glick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 19, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW D.C.</u>	
24a. REC'D BY REGISTRAR <u>W. H. Smith</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	
DATE <u>FEB 16 1958</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
MARRIAGE		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
FEB 18 1958		BUREAU V. L.	
RECEIVED			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2233 CERTIFICATE OF DEATH

Reg. Dist. No. 02211

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Salubran</u>		d. STREET ADDRESS <u>1921 East West Highway</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henderson</u> Last <u>Durand</u>		4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Patent office</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Durand</u>		14. MOTHER'S MAIDEN NAME <u>Williamine Henderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Former Daughter-in-law</u>		Address <u>Nancy F. Durand 4100 Belmont St. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis &amp; left hemiplegia</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Bronchopneumonia, rt. lung base</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 20</u> , 19 <u>58</u> , to <u>Feb 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 13</u> , 19 <u>58</u> , and that death occurred at <u>6:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St N.W. 2-14-58</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Wash 15-D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/17/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Hines co.</u>		ADDRESS <u>2901-14th St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		DATE <u>FEB 19 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 2234 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Eugene</b> Last <b>PAYNE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>18 December 1896</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service, District of Columbia</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>of Columbia</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Wilbur PAYNE</b>				14. MOTHER'S MAIDEN NAME <b>Mildred MASON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes 8-28-17 to 6-20-18</b>				16. SOCIAL SECURITY NO. <b>578-18-8731</b>			
17. INFORMANT <b>(Wife) Mrs. Dorothy L. Payne (Same As #2)</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction, myocardium #4701</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>unknown</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>20 February, 1958</b> , to <b>26 February 1958</b> , that I last saw the deceased alive on <b>26 February, 1958</b> , and that death occurred at <b>9:40 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C.U. Shilling</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>			
DATE SIGNED <b>2-26-58</b>							
PHYSICIAN'S NAME (Type) <b>C.U. SHILLING, LT, MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-28-58 3-3-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.J. Saffell</b>				ADDRESS <b>5th &amp; "H" St., N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>FEB 27 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex	
3. Date of birth		4. Place of birth	
5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death	
9. Signature of physician		10. Signature of registrar	
11. Signature of informant		12. Signature of witness	

BUREAU Y. 4

FEB 27 1958

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02213

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>X Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chestnut St</u>			d. STREET ADDRESS <u>Chestnut St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Frances Louise <del>Teach</del> Peach</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1958</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/1956</u>		9. AGE (In years last birthday) <u>2</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Norman <del>Teach</del> Peach</u>			14. MOTHER'S MAIDEN NAME <u>Estel Anderson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Norman Peach, New Market, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burn involving head body &amp; extremities</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a) <u>  </u> <u>stating the underlying cause lost.</u> (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in burning home</u>			
20c. TIME OF INJURY Month, Day, Year <u>2:40</u> <u>2/8/58</u> Hour <u>  </u> Min. <u>  </u> P.M. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) <u>Gaithersburg</u>	(County) <u>Montg.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/8/58</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 10, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Simpson Chapel</u>		22d. LOCATION (City, town, or county) <u>New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Moleworth</u>		ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>  </u>
DATE <u>FEB 11 '58</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 11 1953

BUREAU V. S.

STATE  
DEATH





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2236

CERTIFICATE OF DEATH

02214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>18 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>734 UNIVERSITY BLVD., EAST</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>734 UNIVERSITY BLVD., EAST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph</b> <sup>First</sup> <b>Walter</b> <sup>Middle</sup> <b>Peed, JR.</b> <sup>Last</sup>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/20/93</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisory Purchasing Agent U.S. Gov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH WALTER PEED</b>		14. MOTHER'S MAIDEN NAME <b>ADDIE VIRGINIA NEALE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>Mrs. Marguerite C. Peed, 734 University Blvd., E. Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition and cachexia and anemia</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cancer of the head of the pancreas and probable metastases</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x</b> <b>Mild diabetes mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>15-18 mos.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>last 10 years</b> to <b>2/26/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/25</b> , 19 <b>58</b> , and that death occurred at <b>12:10A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>500 Underwood St., N.W., Washington, D.C.</b> DATE SIGNED <b>2/26/58</b> ACTUAL SIGNATURE <b>Chas. H. Wolohan</b> M.D. PHYSICIAN'S NAME (Type) <b>Chas. H. Wolohan, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/28/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		24a. REC'D BY REGISTRAR <b>2/28/58</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Humphrey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES A. JONES		38		M		W		1900		BALTIMORE, MD.	
CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
BALTIMORE		BALTIMORE		MD.		FEB 23 1958		HOME		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		SPECIAL INSTRUCTIONS		SIGNATURE OF DECEASED	
LABORER		8		M		C					
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF INTERVIEWER		DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF INTERVIEWER	
FEB 23 1958		J. A. JONES		J. A. JONES		FEB 23 1958		J. A. JONES		J. A. JONES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
FEB 23 1958		HOME		HEART DISEASE		FEB 23 1958		HOME		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
FEB 23 1958		HOME		HEART DISEASE		FEB 23 1958		HOME		HEART DISEASE	

BUREAU V. S.

FEB 28 1958

RECEIVED

## 2237 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Claggettville</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. 2 Monrovia, Md.</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>May</b> Last <b>Perkinson</b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Webster Moxley</b>	
14. MOTHER'S MAIDEN NAME <b>Mary M. Brown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mr. Albert W. Perkinson, Rt. 2 Monrovia, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>5 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Two weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Dec. 10, 1958</b> to <b>2/21, 1958</b> , that I last saw the deceased alive on <b>2/19, 1958</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>James P. Kerr</b> M.D.		ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>	
DATE SIGNED <b>2/23/58</b>		PHYSICIAN'S NAME (Type) <b>Dr. James Kerr</b> <b>Damascus, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/24/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery Chapel, Mont., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONTINUED

01112

and love,

•

Mr. Albert W. Perkins, Jr., 20 Montross

BUREAU V. B.

FEB 26 1958

RECEIVED

Donna Scott

• 2006 •

Montgomery, C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2238 CERTIFICATE OF DEATH

Reg. Dist. No. 02216

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 1 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. PHILOMENA REST HOME</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. PHILOMENA REST HOME</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>S.</b> Last <b>POHZEHL</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>14,</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/15/77</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor of Rooming House</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Woodstock, Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ROBERT WILKIN</b>				14. MOTHER'S MAIDEN NAME <b>ANN R. HAMMOND</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. Andrew Miller, 1901 Henderson Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>10 yr</b>				INTERVAL BETWEEN ONSET AND DEATH <b>one wk</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2-3, 1957</b> to <b>2-14, 1958</b> , that I last saw the deceased alive on <b>2-9-</b> , 1958, and that death occurred at <b>1:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2205 Richland St., Silver Spring, Md.</b> DATE SIGNED <b>2/14/58</b>							
ACTUAL SIGNATURE <b>Harry J. Kicherer</b>				M.D. <b>2205 Richland St., Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>HARRY J. KICHERER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>2/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner B. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 21 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overman</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

**BUREAU V. S.**

FEB 21 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02217

Item 4 Film G226 2-28-58 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7030 Armat Drive</b>		d. STREET ADDRESS <b>7030 Armat Drive</b>	
3. NAME OF DECEASED (Type or print) <b>James L. POWERS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1906</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>	
11. BIRTHPLACE (State or foreign country) <b>Newfoundland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>James Powers</b>		14. MOTHER'S MAIDEN NAME <b>Clara Tobin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Selma C. Powers</b>		Address <b>same as 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b></b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/21/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred...</b>			

FEB 24 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 10a, 10b, 15b, Fil-G226 3-6-58 et

## 2240 CERTIFICATE OF DEATH

02218

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write <u>Bethesda (Rural)</u> ) RURAL and give nearest town				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Ewing</u> Last <u>RICE, III</u>				4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 July 1905</u>		9. AGE (In years last birthday) <u>52</u> yns.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner Lawyer &amp; Judge</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy U.S. Tax Court</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephen E. RICE</u>				14. MOTHER'S MAIDEN NAME <u>Carolyn FLOYD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT (Wife) <u>Mrs. Lida J. RICE (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral neoplasm (probable)</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic bronchogenic carcinoma</u> 6+ months DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 January, 19 58</u> , to <u>9 February, 19 58</u> , that I last saw the deceased alive on <u>9 February, 19 58</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.G. Galbraith, Jr.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 2-10-58</u>			
PHYSICIAN'S NAME (Type) <u>R.G. GALBRAITH, JR. LT, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>520 S. Washington St. Alexandria, Va.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 11 58</u>		24b. REGISTRAR'S SIGNATURE <u>Aut. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

## CERTIFICATE OF DEATH

BUREAU V. 51

FEB 11 1958

RECEIVED



2115

## CERTIFICATE OF DEATH

02219

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Oaklawn Nursing Home</b>		d. STREET ADDRESS <b>7104 CHESTNUT ST. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NANNIE</b> Middle <b>S.</b> Last <b>RICHARDS.</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>11</b> Year <b>19-58</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 15, 1876</b>
9. AGE (In years less birthday) <b>81</b> yrs.		IF UNDER 1 YEAR: Months <b>1</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>-----</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Woods</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Sullivan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Harry Richards</b>		Address <b>7125 Piney Branch Rd. N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum</b> <b>154X</b> DUE TO <b>-----</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> DUE TO <b>-----</b> (c) <b>-----</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month <b>Jan.</b> Day <b>13</b> Year <b>1958</b> Hour <b>19</b> a. m. <b>-----</b> p. m. <b>-----</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 13, 1958</b> to <b>Feb. 11, 1958</b> , that I last saw the deceased alive on <b>Feb. 11, 1958</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lynwood Heiges</b>		ADDRESS (Street, city or town, state) <b>6940 PINEY BRANCH RD. N.W. WASH. D.C.</b>	
PHYSICIAN'S NAME (Type) <b>LYNWOOD HEIGES, M.D., F.A.C.A.</b>		DATE SIGNED <b>2-11-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>2/12/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 13 '58</b>	
ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18

NAME OF DECEASED ANNIE E. RICHARDS		AGE 12, 1825	SEX F	RACE W	DATE OF DEATH FEB. 11, 1928	PLACE OF DEATH 114 CHESTNUT ST. WASH. D.C.
CAUSE OF DEATH		MANNER OF DEATH				

Government of District

RECEIVED  
 WASHINGTON, D.C.  
 1928  
 JAN. 13  
 FEB. 11  
 BUREAU V. 3  
 1928

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2116 CERTIFICATE OF DEATH

02220

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b <b>17</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>708 Philadelphia Avenue</b>				d. STREET ADDRESS <b>708 Philadelphia Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Lillian A</b> Middle <b>Ritter</b> Last <b>Ritter</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/9/1875</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>		IF UNDER 24 HRS. Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>New Hampshire</b>			
11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>				12. CITIZEN OF WHAT COUNTRY? <b>New Hampshire</b>			
13. FATHER'S NAME <b>David A. Ritter</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Elizabeth Stearns</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Washington, DC</b>			
17. INFORMANT <b>Mary Evelyn Bakhsh-1636 Kenyon St. N.W.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>332x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b>?</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>19 53</b> to <b>20 Feb</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>20 Feb</b> , 19 <b>58</b> , and that death occurred at <b>1:30 P</b> . M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>9006 Chesville Rd</b> DATE SIGNED <b>2/20/58</b>			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.							
PHYSICIAN'S NAME (Type) <b>William D. Aud</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.-2901 14th St., N.W.</b>				24a. REC'D BY REGISTRAR <b>FEB 24 58</b>			
24b. REGISTRAR'S SIGNATURE <b>Reed</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8561 24 1958

RECEIVED

Reg. Dist. No. 02221

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8602 - 11th Ave.</b>		d. STREET ADDRESS <b>8602 - 11th Ave - 1</b>	
3. NAME OF DECEASED (Type or print) <b>Emily C. Rose</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>84</b>
11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>VINCENT BURCH.</b>		14. MOTHER'S MAIDEN NAME <b>MARY C. PENN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>WALTER H. ROSEN</b>		Address <b>8602 - 11th Ave Silver Spring Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident - recurrent</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>one (1) mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 1953</b> , to <b>Feb 10 1958</b> , that I last saw the deceased alive on <b>Feb 10 1958</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ernest A. Sarao</b>		ADDRESS (Street, city or town, state) <b>7006 New Hampshire Ave M.D.</b>	
PHYSICIAN'S NAME (Type) <b>ERNEST A. SARAO</b>		DATE SIGNED <b>2/11/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Buried</b>	<b>Feb 14 1958</b>	<b>Arlington Nat.</b>	<b>Arlington VA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee Son</b>		ADDRESS <b>Wash. D.C.</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <b>FEB 13 58</b>		<b>Ch. J. J. J.</b>	

VS A15 (4)  
15M 10/57



# MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore

## CERTIFICATE OF DEATH

BUREAU V. 3

FEB 18 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2117 CERTIFICATE OF DEATH

Reg. Dist. No. 03585

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San</i>		d. STREET ADDRESS <i>410 Nicholson St NW</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Sola</i> Middle <i>Rosenthal</i> Last <i>Rosenthal</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>11</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/15-1895</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House duties</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Wm</i>	
14. MOTHER'S MAIDEN NAME <i>Sylvia</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>519-484767</i>		17. INFORMANT <i>Stanley Rosenthal</i> Address <i>414 Jefferson NE</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> <i>153.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma of cecum</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Essential Hypertension</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 10</i> , 19 <i>54</i> , to <i>Feb 11</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Feb 10</i> , 19 <i>58</i> , and that death occurred at <i>4:16 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur S. Bresler</i> M.D.		ADDRESS (Street, city or town, state) <i>533 Rye Rd N.E.</i> DATE SIGNED <i>2-11-58</i>	
PHYSICIAN'S NAME (Type) <i>ARTHUR S. BRESLER</i>		<i>Washington, D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/12-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Helesaretgrad Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Washington DC</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i> ADDRESS <i>Washington D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 10 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Bresler</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10-1

PLACE OF BIRTH (State, Territory, Possession, Country, etc.)		PLACE OF DEATH (State, Territory, Possession, Country, etc.)	
DATE OF BIRTH (Month, Day, Year)		DATE OF DEATH (Month, Day, Year)	
SEX Male <input type="checkbox"/> Female <input type="checkbox"/>		RACE White <input type="checkbox"/> Negro <input type="checkbox"/> Other <input type="checkbox"/>	
OCCUPATION (If deceased, state occupation of decedent; if living, state occupation of informant)		CAUSE OF DEATH (State immediately preceding cause of death)	
MANNER OF DEATH Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/>		MEDICAL HISTORY (State any chronic or other diseases, habits, etc.)	
SIGNATURE OF DECEASED (If living, state name of decedent; if deceased, state name of informant)		SIGNATURE OF INFORMANT (If living, state name of informant; if deceased, state name of decedent)	
SIGNATURE OF PHYSICIAN (If living, state name of physician; if deceased, state name of decedent)		SIGNATURE OF CORONER (If living, state name of coroner; if deceased, state name of decedent)	
SIGNATURE OF JUDGE (If living, state name of judge; if deceased, state name of decedent)		SIGNATURE OF CLERK (If living, state name of clerk; if deceased, state name of decedent)	

BUREAU V. S.

MAR 10 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2242 CERTIFICATE OF DEATH

02222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASHINGTON, D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>18 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL HALL SANITARIUM</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. STREET ADDRESS <b>3900 16th St., N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rachelle</b> First <b>Rosinger</b> Middle <b>Rosinger</b> Last		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/22/1884</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUSTRIA</b>	
11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD PRAGER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>KURT E. ROSINGER, 3900 16th St., N.W., D. C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332x</b> DUE TO <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>7 wks.</b> <b>8 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Syndrome, arteriosclerotic</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-3</b> , 19 <b>54</b> , to <b>2-28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-27</b> , 19 <b>58</b> , and that death occurred at <b>9:55 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas A. Wildman</b>		M.D. <b>3729 Morrison St. N.W., Wash. 15, D.C.</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS A. WILDMAN</b>		<b>3729 MORRISON ST., N.W., WASH. 15, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>2/28/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gaudin's Sons</b>		ADDRESS <b>1756 Pa. Ave., N.W., D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2243

## CERTIFICATE OF DEATH

02223

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville-Rural</b>				c. LENGTH OF STAY IN 1b <b>6 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Philomenas Rest Home, 14901-Ga. Ave</b>				d. STREET ADDRESS <b>3109-Windon Rd</b>			
3. NAME OF DECEASED (Type or print) <b>Cora A Ryman</b>				4. DATE OF DEATH <b>Feb 25 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 6- 1873</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>			
13. FATHER'S NAME <b>George Frye</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Coffman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Norman Ryman, 3109 Windon Rd. Mt. Rainier, Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>20 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>24 hr</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>2-2-1958</b> , to <b>2-25-1958</b> , that I last saw the deceased alive on <b>2-2-1958</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>2205 Richland St, Silver Spring, Md</b>				DATE SIGNED			
ACTUAL SIGNATURE <b>Harry A. Kicherer</b> M.D.				PHYSICIAN'S NAME (Type) <b>Harry A. Kicherer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton, Barnesville, Md</b>				24a. REC'D BY REGISTRAR <b>FEB 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Quib...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 28 1958

RECEIVED

## 2244 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montg</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington Grove</b>		c. LENGTH OF STAY IN 1b <b>18yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Washington Grove</b>	
		d. STREET ADDRESS <b>/</b>	
3. NAME OF DECEASED (Type or print) First <b>Girtrude</b> Middle <b>May</b> Last <b>Rynex</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>7th</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug 28-1875</b>
9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Robenson</b>		14. MOTHER'S MAIDEN NAME <b>Mary D. Azbell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Frank Allen Rynex, Washington Grove, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BACTEREMIA AND BROWHYMOMYXIA</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL HEMORRHAGE</b> DUE TO (c) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>21 DAYS</b> <b>20 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 22, 1958</b> , to <b>FEB. 7, 1958</b> , that I last saw the deceased alive on <b>FEB. 7, 1958</b> , and that death occurred at <b>10:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b> M.D.		ADDRESS (Street, city or town, state) <b>26 N. Summit Ave. Feb 7, 1958</b>	
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>		DATE SIGNED <b>GARTENSBURG, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 11 1958</b>	
		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

2245 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Montgomery County General Hospital, Inc.</b>		d. STREET ADDRESS <b>04X-2</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Daniel</b> Last <b>SAMPSON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
13. FATHER'S NAME <b>George David Sampson</b>		14. MOTHER'S MAIDEN NAME <b>Siedenstricker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Harold L. Sampson Silver Spring, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 450.0 DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease - Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/8</b> , 19 <b>58</b> , to <b>2/14</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/14</b> , 19 <b>58</b> , and that death occurred at <b>11:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard A. Yates</b>		ADDRESS (Street, city or town, state) <b>Olney, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>R. A. Yates, M. D.</b>		DATE SIGNED <b>2/15/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 17, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home.</b>		ADDRESS <b>Washington D.C.</b>	
24a. REC'D BY REGISTRAR <b>EB 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED George Daniel		AGE 35		SEX Male		RACE White		DATE OF BIRTH 1901		PLACE OF BIRTH Maryland	
MARRIAGE Married		DATE OF MARRIAGE 1925		PLACE OF MARRIAGE Baltimore		NAME OF SPOUSE Mary		DATE OF DEATH 1936		PLACE OF DEATH Baltimore	
CAUSE OF DEATH Heart Disease		PERIOD OF ILLNESS 3 days		PLACE OF ILLNESS Home		NAME OF PHYSICIAN Dr. J. H. Smith		DATE OF EXAMINATION 1936		PLACE OF EXAMINATION Baltimore	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF DECEASED George Daniel		SIGNATURE OF SPOUSE Mary		SIGNATURE OF WITNESS John Doe		SIGNATURE OF WITNESS Jane Doe		SIGNATURE OF WITNESS Bob Doe	
DATE OF DEATH 1936		PLACE OF DEATH Baltimore		NAME OF PHYSICIAN Dr. J. H. Smith		DATE OF EXAMINATION 1936		PLACE OF EXAMINATION Baltimore		SIGNATURE OF PHYSICIAN Dr. J. H. Smith	

BUREAU V. 3

FEB 21 1936

RECEIVED

## 2246 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS SANITARIUM</b>		d. STREET ADDRESS <b>5320 CHILLUM PL. N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SALVATORE</b> Middle Last <b>SCALCO</b>		4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>8/7/81</b>	9. AGE (In years last birthday) yrs. <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Italy</b>
13. FATHER'S NAME <b>Rito Scalco</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Marino</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Rito Scalco</b>		<b>5320 Chillum Place N.E. Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Infarct</b> 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arricular Fibrillation</b> DUE TO (c) <b>Atherosclerosis, severe, generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 20, 1958</b> to <b>Feb. 23, 1958</b> that I last saw the deceased alive on <b>Feb. 23, 1958</b> , and that death occurred at <b>8:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D.		ADDRESS (Street, city or town, state) <b>10609 CONCORD ST. WASHINGTON, D.C.</b> DATE SIGNED <b>2-23-58</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT T. THIBADEAU</b>		<b>KENSINGTON, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>2/26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.W. Washington 9, D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>FEB 26 '58</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11-11-2010 BY 60322 UCBAW/BJS

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		U.S.A.			
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE			
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED			
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS			
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE			
APRIL 10, 1968		APRIL 10, 1968		APRIL 10, 1968		APRIL 10, 1968		APRIL 10, 1968		APRIL 10, 1968		APRIL 10, 1968		APRIL 10, 1968			

**RECEIVED**  
FEB 26 1958  
BUREAU V. 3

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02227

Item 14, Film G225 2/10/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4807 Chevy Chase Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4807 Chevy Chase Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leon Joseph Segal</u>		4. DATE OF DEATH <u>Feb 5 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-98</u>
9. AGE (In years last birthday) <u>59 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>translator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mordecai Segal</u>		14. MOTHER'S MAIDEN NAME <u>Dora Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>8228 New Hampshire</u>	
17. INFORMANT <u>Bernard Segal, Silver Spring Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broseant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broseant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 6, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Okech Shalom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington - D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Janzansky &amp; Son - 3501-15th St NW</u>		24a. REC'D BY REGISTRAR <u>Feb 7 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. CHIEF CLERK

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

RECEIVED  
FEB 7 1953  
BUREAU V. S.



03590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. Gen. Hosp.</b>		d. STREET ADDRESS <b>Box 56</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>GERTRUDE</b> Last <b>SHAW</b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/4/82</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Tyson Baker</b>		14. MOTHER'S MAIDEN NAME <b>Edith Sullivan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>8 yrs.</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 48</b> to <b>Feb 21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 21</b> , 19 <b>58</b> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2-21-58</b> <b>Richard A. Yates</b> M.D. <b>(3-21-58)</b>			
22a. PHYSICIAN'S NAME (Type) <b>Richard A. Yates, M.D.</b> <b>Olney, Maryland</b>			
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/24/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>COLESVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. E. Pumphrey</b>			

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MB 3/17/58

# CERTIFICATE OF DEATH

Replacement certificate - Original lost  
in mail 3/26/18-MB

BUREAU V. 3

MAR 27 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2249 CERTIFICATE OF DEATH

Reg. Dist. No. 12228

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u> 13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>SKILLINGER Lillian Conwell Skillinger</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/89</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Joseph D. Conwell</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Joyce</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>J.E. Skillinger - husband</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>3 mos.</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>58</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates</u>		ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>2/12/58</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. YATES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ECHIGIN BATHON, ELLIOTT CITY Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>FEB 18 '58</u> DATE 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

BUREAU V. S.

FEB 18 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2250 CERTIFICATE OF DEATH

02229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 15 <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc</b>				d. STREET ADDRESS <b>Rt. #1 Norwood Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Owen</b> Middle <b>Witlynn</b> Last <b>Shoemaker</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/25/84</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>William Shoemaker</b>				14. MOTHER'S MAIDEN NAME <b>Betty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-30-3397</b>		17. INFORMANT <b>Flora Shoemaker</b> Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO <b>443 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Prostate</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>July 19 55</b> to <b>Feb 24 19 58</b> , that I last saw the deceased alive on <b>2-26-23</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2-24-58</b>							
ACTUAL SIGNATURE <b>Jack Schumacher</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Jack Schumacher, M. D.</b>				Gaithersburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fred Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 26 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		FEBRUARY 26, 1953	
AGE		SEX	
65		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		PLACE OF BIRTH	
Retired		Maryland	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
Myocardial Infarction		Coronary Artery Disease	
PREVIOUS ILLNESS		DATE OF ONSET	
None		None	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
February 26, 1953		Home	
SIGNATURE OF PHYSICIAN		DATE	
J. H. Harris		February 26, 1953	
SIGNATURE OF REGISTRAR		DATE	
J. H. Harris		February 26, 1953	

RECEIVED  
FEB 26 1953  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2251 CERTIFICATE OF DEATH

02230

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>118 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Wheaton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>2600 Dawson Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Peter</u> Middle <u>P.</u> Last <u>Sintetos</u>				<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>24</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1890</u>		9. AGE (In years last birthday) <u>67 yrs.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor Business</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Panagiotis Sintetos</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Colofiras</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-03-8656</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PERITONITIS; EMPYEMA OF GALLBLADDER</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RENAL CELL CARCINOMA METASTATIC TO BRAIN, HEART, LUNGS, SPINE, LYMPH NODES</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 yrs</u>
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>October 30, 19 57</u> <b>to</b> <u>February 24, 19 58</u> <b>that I last saw the deceased alive on</b> <u>February 24, 19 58</u> <b>and that death occurred at</b> <u>1:35 P</u> <b>M, from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <u>Edward W. Moore</u> <b>M.D.</b> <u>The Clinical Center</u> <b>DATE SIGNED</b> <u>2-25-58</u> <b>PHYSICIAN'S NAME (Type)</b> <u>Edward W. Moore, M. D.</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>2/27/58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>PARKLAWN CEMETERY</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Humphrey</u>				<b>ADDRESS</b> <u>SILVER SPRING, MD.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>FEB 28 '58</u>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Rebecca</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE CLERK OF THE DISTRICT COURT  
FOR THE DISTRICT OF  
BALTIMORE

BURMAN V. S.

FEB 28 1938

RECEIVED

2252

## CERTIFICATE OF DEATH

Reg. Dist. No. 02231

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Norbeck</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Norbeck RFD Silver Spring,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Motley Rest Home</b>				d. STREET ADDRESS <b>RURAL -- Cabin John</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Raymond Clyde Sipes</b>				4. DATE OF DEATH Month Day Year <b>February 14 1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 6, 1892</b>		9. AGE (In years lost birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>11 9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never worked</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Sipes</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>John T. Sipes 6510-78th St. Cabin John</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> <b>096.9</b> DUE TO <b>Complicating Intestinal Virus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Emphysema &amp; Cardiorenal Hypertension</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiplegia. Dementia. Bilateral Inguinal Herniae.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 23, 1957</b> , to <b>Feb. 14, 1958</b> , that I last saw the deceased alive on <b>Feb. 14, 1958</b> , and that death occurred at <b>4:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Norbeck, RFD Silver Spring, Md.</b> DATE SIGNED <b>2/15</b>							
ACTUAL SIGNATURE <b>Webster Sewell</b> M.D.				PHYSICIAN'S NAME (Type) <b>Webster Sewell, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Potomac Church</b>		22d. LOCATION (City, town, or county) (State) <b>Potomac, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Seach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. SIGNATURE OF PHYSICIAN [REDACTED]	
10. SIGNATURE OF REGISTRAR [REDACTED]		11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]	
13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF DECEASED [REDACTED]		15. SIGNATURE OF DECEASED [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF DECEASED [REDACTED]		18. SIGNATURE OF DECEASED [REDACTED]	
19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF DECEASED [REDACTED]		21. SIGNATURE OF DECEASED [REDACTED]	
22. SIGNATURE OF DECEASED [REDACTED]		23. SIGNATURE OF DECEASED [REDACTED]		24. SIGNATURE OF DECEASED [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF DECEASED [REDACTED]		27. SIGNATURE OF DECEASED [REDACTED]	
28. SIGNATURE OF DECEASED [REDACTED]		29. SIGNATURE OF DECEASED [REDACTED]		30. SIGNATURE OF DECEASED [REDACTED]	
31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF DECEASED [REDACTED]		33. SIGNATURE OF DECEASED [REDACTED]	
34. SIGNATURE OF DECEASED [REDACTED]		35. SIGNATURE OF DECEASED [REDACTED]		36. SIGNATURE OF DECEASED [REDACTED]	
37. SIGNATURE OF DECEASED [REDACTED]		38. SIGNATURE OF DECEASED [REDACTED]		39. SIGNATURE OF DECEASED [REDACTED]	
40. SIGNATURE OF DECEASED [REDACTED]		41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF DECEASED [REDACTED]	
43. SIGNATURE OF DECEASED [REDACTED]		44. SIGNATURE OF DECEASED [REDACTED]		45. SIGNATURE OF DECEASED [REDACTED]	
46. SIGNATURE OF DECEASED [REDACTED]		47. SIGNATURE OF DECEASED [REDACTED]		48. SIGNATURE OF DECEASED [REDACTED]	
49. SIGNATURE OF DECEASED [REDACTED]		50. SIGNATURE OF DECEASED [REDACTED]		51. SIGNATURE OF DECEASED [REDACTED]	
52. SIGNATURE OF DECEASED [REDACTED]		53. SIGNATURE OF DECEASED [REDACTED]		54. SIGNATURE OF DECEASED [REDACTED]	
55. SIGNATURE OF DECEASED [REDACTED]		56. SIGNATURE OF DECEASED [REDACTED]		57. SIGNATURE OF DECEASED [REDACTED]	
58. SIGNATURE OF DECEASED [REDACTED]		59. SIGNATURE OF DECEASED [REDACTED]		60. SIGNATURE OF DECEASED [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF DECEASED [REDACTED]		63. SIGNATURE OF DECEASED [REDACTED]	
64. SIGNATURE OF DECEASED [REDACTED]		65. SIGNATURE OF DECEASED [REDACTED]		66. SIGNATURE OF DECEASED [REDACTED]	
67. SIGNATURE OF DECEASED [REDACTED]		68. SIGNATURE OF DECEASED [REDACTED]		69. SIGNATURE OF DECEASED [REDACTED]	
70. SIGNATURE OF DECEASED [REDACTED]		71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF DECEASED [REDACTED]	
73. SIGNATURE OF DECEASED [REDACTED]		74. SIGNATURE OF DECEASED [REDACTED]		75. SIGNATURE OF DECEASED [REDACTED]	
76. SIGNATURE OF DECEASED [REDACTED]		77. SIGNATURE OF DECEASED [REDACTED]		78. SIGNATURE OF DECEASED [REDACTED]	
79. SIGNATURE OF DECEASED [REDACTED]		80. SIGNATURE OF DECEASED [REDACTED]		81. SIGNATURE OF DECEASED [REDACTED]	
82. SIGNATURE OF DECEASED [REDACTED]		83. SIGNATURE OF DECEASED [REDACTED]		84. SIGNATURE OF DECEASED [REDACTED]	
85. SIGNATURE OF DECEASED [REDACTED]		86. SIGNATURE OF DECEASED [REDACTED]		87. SIGNATURE OF DECEASED [REDACTED]	
88. SIGNATURE OF DECEASED [REDACTED]		89. SIGNATURE OF DECEASED [REDACTED]		90. SIGNATURE OF DECEASED [REDACTED]	
91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF DECEASED [REDACTED]		93. SIGNATURE OF DECEASED [REDACTED]	
94. SIGNATURE OF DECEASED [REDACTED]		95. SIGNATURE OF DECEASED [REDACTED]		96. SIGNATURE OF DECEASED [REDACTED]	
97. SIGNATURE OF DECEASED [REDACTED]		98. SIGNATURE OF DECEASED [REDACTED]		99. SIGNATURE OF DECEASED [REDACTED]	
100. SIGNATURE OF DECEASED [REDACTED]		101. SIGNATURE OF DECEASED [REDACTED]		102. SIGNATURE OF DECEASED [REDACTED]	

BUREAU V. S.

FEB 24 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2253

## CERTIFICATE OF DEATH

Reg. Dist. No.

02232

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE 13111 VALLEYWOOD</u>				d. STREET ADDRESS <u>13111 VALLEYWOOD DRIVE</u>			
3. NAME OF DECEASED (Type or print) First <u>SEANIE</u> Middle <u>DUDLEY</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/1/68</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>AXXANDRIA, VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>MARCELLUS MAXS</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA SCRUGGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. Joseph A. Fried, 13,111 Valleywood Dr. Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO-SCLEROTIC CARDIO VASCULAR RENAL DISEASE</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>FEBRUARY, 1957</u> , to <u>2/5</u> , 1958, that I last saw the deceased alive on <u>1/5</u> , 1958, and that death occurred at <u>10:30AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>10011 GEORGIA AVE</u>				DATE SIGNED <u>2/6/58</u>			
ACTUAL SIGNATURE <u>Henry W. Stout MD</u>				M.D. <u>10011 GEORGIA AVE</u>			
PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT MD</u>				<u>SILVER SPRING, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 1958</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

FEB 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02233

## 2254 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Onley</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. General Hosp.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Echison</b>	
3. NAME OF DECEASED (Type or print) <b>OLIVER<sup>First</sup> PERRY<sup>Middle</sup> SNYDER<sup>Last</sup></b>		4. DATE OF DEATH <b>February 9 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31 1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oliver P. Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Annie Mary Hilton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Annie M. Hilton</b>		Address <b>Same AS 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of prostate</b> DUE TO <b>7 years</b> (c) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 6, 1949</b> , to <b>February 9, 1958</b> , that I last saw the deceased alive on <b>February 8, 1958</b> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>Feb, 9</b>			
ACTUAL SIGNATURE <b>James P. Kerr</b>		M.D. <b>Damascus Md.</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>		<b>Damascus Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11 58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Raymond Barber</b>	

CERTIFICATE OF DEATH

Name of Deceased		Olivier F. Snyder	
Sex		Male	
Race		White	
Date of Birth		July 31 1874	
Age		83	
Marital Status		Married	
Spouse's Name		Annie Mary Hilton	
Occupation		Retired Farmer	
Place of Birth		Maryland	
U.S.A.		U.S.A.	
Cause of Death		None	
Date of Death		February 3 1958	
Place of Death		Baltimore, Md.	
Physician's Name		Dr. J. H. Oliver	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		February 11 1958	
Bureau V. S.		Bureau V. S.	
RECEIVED		RECEIVED	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2255

## CERTIFICATE OF DEATH

02234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>114 W. Irving</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Alonso</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>September 4, 1888</u> 69 yrs.
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>23</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Fife Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Isis Ingelby Woodford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Army</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Miss Ethel Anne Snyder</u>		Address <u>588 14th St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Pulmonary Hypertension - Rt and Left Heart Failure</u> DUE TO (c) <u>Obstructive Emphysema and Bronchial Asthma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 February, 1958</u> , to <u>27 February, 1958</u> , that I last saw the deceased alive on <u>27 February, 1958</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Witowski</u>		ADDRESS (Street, city or town, state) <u>SUITE 400, 8218 WISCONSIN AVE.</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. WITOWSKI, JR.</u>		DATE SIGNED <u>2/29/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3/3/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>7557 Wis. Ave. Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>Alf Leach</u>		24b. REGISTRAR'S SIGNATURE <u>Alf Leach</u>	

MEDICAL CERTIFICATION

2

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74

N

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE	
EDUCATION		HIGHER		HIGHER		HIGHER		HIGHER		HIGHER	
OCCUPATION		BUSINESS		BUSINESS		BUSINESS		BUSINESS		BUSINESS	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
PLACE OF DEATH		HOME		HOME		HOME		HOME		HOME	
DATE OF DEATH		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	
TIME OF DEATH		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
SIGNATURE OF DECEASED		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF WITNESSES		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF PHYSICIAN		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF CORONER		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF JURY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF JUDGE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF CLERK		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF SHERIFF		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF DISTRICT ATTORNEY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF COUNTY CLERK		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF TOWNSHIP CLERK		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF VOTING CLERK		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF JURY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF JUDGE		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF CLERK		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF SHERIFF		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF DISTRICT ATTORNEY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF COUNTY CLERK		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF TOWNSHIP CLERK		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
SIGNATURE OF VOTING CLERK		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

MAR 3 1968

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2256

12235

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY in 1b <b>35 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>#9 Chevy Chase Circle</b>			d. STREET ADDRESS <b>#9 Chevy Chase Circle</b>		
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>SPARKS</b> Last <b>SPARKS</b>			4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1884</b>		9. AGE (in years last birthday) <b>73</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>		11. BIRTHPLACE (State or foreign country) <b>Charlottesville, Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jack Sparks</b>			14. MOTHER'S MAIDEN NAME <b>? Deanie</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Walter Jenkins-sister</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>found dead in bed</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of throat for two years</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Washington</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2/25/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>McGuire Funeral Home</b>	
22d. LOCATION (City, town, or county) <b>Washington</b>		22e. (State) <b>Dist. Col.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</b>		24a. REC'D BY REGISTRAR <b>FEB 27 '58</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

*[Signature]*

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

**Frank J. Broschart, M.D.**

DEPUTY MEDICAL EXAMINER ☒

**February 24, 1958**

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

**Removal**

**2/25/1958**

**McGuire Funeral Home**

**Washington**

**Dist. Col.**

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

**Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md**

**FEB 27 '58**

DATE

*[Signature]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, or in any event within 72 hours after death.

1958 FEB 27

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02236

2257

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2709 Fenimore Rd.</b>			d. STREET ADDRESS <b>2709 Fenimore Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>W</b> Last <b>Steers</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>16,</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/13/1900</b>		9. AGE (In years last birthday) <b>57</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Wm. W. Steers</b>		
14. MOTHER'S MAIDEN NAME <b>Whitner</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year of date of service) <b>WW I</b>		
16. SOCIAL SECURITY NO. <b>—</b>			17. INFORMANT <b>Pauline E. Steers (wife)</b> Address <b>Item 2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/17/58</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walters</b>		ADDRESS <b>254 Carroll St NW D.C.</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF  
HEALTH DEPT.

BUREAU V. B.

FEB 18 1958

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02237

2258

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery County General Hospital, Inc.</b>		d. STREET ADDRESS <b>2473 Callow Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Elva</b> Middle <b>Stoler</b> Last <b>Stoler</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 12, 1907</b> 9. AGE (In years last birthday) <b>48</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Hurwitz</b>		14. MOTHER'S MAIDEN NAME <b>Lena Davidson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Isabore Goldberg</b>		Address <b>1022 Quebec Ter. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thoracic Hemorrhage</b> <b>825x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>crushed chest</b> DUE TO (c) <b>auto accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>25 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Fracture of jaw, left and fracture of left ankle.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was passenger in car involved in auto accident.</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:00 p.m. 2/4/58 19</b>		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. R. 29,</b>		20f. (City or town) <b>Burtonsville</b> (County) <b>Montg.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> February 5, DATE SIGNED 1958.	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-6-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Hebrew</b>		22d. LOCATION (City, town, or county) <b>Balto</b> (State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc</b>		ADDRESS <b>2100 Euton Place</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Outreach</b>	
DATE <b>FEB 7 '58</b>			

BUREAU V. 5

FEB 7 1958

RECEIVED

2259

## CERTIFICATE OF DEATH

Reg. Dist. No.

02238

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1914 Stratton Road</b>				d. STREET ADDRESS <b>1914 Stratton Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CLARINDA</b> Middle <b>CROUTE</b> Last <b>STOUT</b>				4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 8, 1876</b>	9. AGE (In years last birthday) yrs. <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Olney, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Croute</b>				14. MOTHER'S MAIDEN NAME <b>Malinda Lilly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Mation H. Stout, 1914 Stratton Road, Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis - Generalized</b> DUE TO <b>+ Cerebral -</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 9, 1956</b> , to <b>Feb 4, 1958</b> , that I last saw the deceased alive on <b>Feb 4, 1958</b> , and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sancti Park, Maryland</b> DATE SIGNED <b>Feb 4 '58</b> ACTUAL SIGNATURE <b>Joseph H. Watson</b> M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Interlaken, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph H. Watson</b>				ADDRESS <b>1756 Pennsylvania Ave NW, Washington, D C</b>		24a. REC'D BY REGISTRAR <b>Feb 6 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 6 1958

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G225 2-11-58 et

2260

CERTIFICATE OF DEATH

02239

Reg. Dist. No.

215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orange City</b>	
c. LENGTH OF STAY IN 1b <b>77 days</b>		d. STREET ADDRESS <b>P.O. Box 565</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Albert TALLMAN</b>		4. DATE OF DEATH Month Day Year <b>February 1 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 December 1879</b>
9. AGE (In years lost birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Richard P. TALLMAN</b>		14. MOTHER'S MAIDEN NAME <b>Mary DELACY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Sp. Am. WW-II &amp; I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Official Navy Records)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, Squamous cell, Tongue</b> 141.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs (approx.)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 November, 1957</b> , to <b>1 February, 1958</b> , that I last saw the deceased alive on <b>1 February, 1958</b> , and that death occurred at <b>9:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 2-3-58</b>			
ACTUAL SIGNATURE <b>M.C. Shea</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>M.C. SHEA, LT, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-6-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 6 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



CERTIFICATE OF DEATH

FILE NO. 114

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

U.S. BIRTH

U.S. CITIZENSHIP

U.S. RESIDENCE

U.S. OCCUPATION

U.S. MARITAL STATUS

U.S. RELIGION

U.S. ETHNIC ORIGIN

U.S. ANCESTRY

U.S. LANGUAGE

U.S. CULTURE

U.S. IDENTITY

U.S. BELONGING

U.S. AFFILIATION

U.S. CONNECTION

U.S. LINKAGE

BURIAL IN 11

FEB. 6 - 1958

RECEIVED

2261

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Sp.</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 8668 Piney Branch Road</b>	
f. STREET ADDRESS <b>Silver Spring, Apt. T4</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Askins Thornton</b>		4. DATE OF DEATH <b>February 23 1958</b>	
5. SEX <b>fem</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1902</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper family</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Montg. Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elliot Askins</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Frances Johnson</b>		18. 8668 Garland Ave., Takoma Park, Md. T4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 25</b> , 19 <b>34</b> , to <b>Feb. 23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 23</b> , 19 <b>58</b> , and that death occurred at <b>10:07 M.</b> from the causes and on the date stated above. P ADDRESS (Street, city or town, state) <b>Norbeck Rt. 1 Silv. Sp., Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Webster Sewell</b>		M.D. <b>Webster Sewell, M.D.</b>	
22a. BURIAL, CREMATION, BENEFIT (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sworden</b>		ADDRESS <b>Rookville, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overseer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02241

2262

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>12 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2913 Stanton Ave.</b>		d. STREET ADDRESS <b>2913 Stanton Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Kelley Thulman</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>18,</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/31/1898</b>
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months <b>59</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>engineer (mechanical)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chimney Sales Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John A. Thulman</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Kelley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW #1</b>		16. SOCIAL SECURITY NO. <b>220-32-6316</b>	
17. INFORMANT <b>Katherine D. Thulman (wife)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>2/19/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/22/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Q. E. ...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. E.

FEB 24 1958

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2118

## CERTIFICATE OF DEATH

02242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>2 months</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 TAKOMA PARK</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1105 Kirklynn Avenue</b>			
d. STREET ADDRESS <b>1105 Kirklynn Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>M.</b> Last <b>THURMAN</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>18</b> Year <b>19 58</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/30/73</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER &amp; FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>TUNNEL, OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID THURMAN</b>				14. MOTHER'S MAIDEN NAME <b>EMILE LONGFELLOW</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-14-7131</b>		17. INFORMANT <b>Mrs. Arthur E. Housman, 1105 Kirklynn Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/12</b> , 19 <b>47</b> , to <b>2/18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/18/58</b> , 19 <b>58</b> , and that death occurred at <b>4:23 p.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dean H. Harding</b>		M.D. <b>113 Canoll ST. NW, Wash D.C.</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>2/19/58</b>	
PHYSICIAN'S NAME (Type) <b>DEAN H. HARDING</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BURTONSVILLE, MONTGOMERY CO., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter L. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>FEB 24 58</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 68	
DATE OF DEATH 10/15/1958		PLACE OF DEATH Home		COUNTY Baltimore	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH 10/15/1890		SEX Male	
OCCUPATION Retired		MARITAL STATUS Married		EDUCATION High School	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF JURY (None)		SIGNATURE OF JUDGE (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)		SIGNATURE OF COMMISSIONER (None)	

BUREAU V. E.

13 24 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2263

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

02243

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>21</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>1 hr. 4 min.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>TOWNSEND</b>			4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>19 58</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 February 1958</b>		9. AGE (In years last birthday) yrs. <b>4</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Edward Francis TOWNSEND</b>			14. MOTHER'S MAIDEN NAME <b>Mary Jane ECKEL</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>(Father) Edward F. Townsend (Same As #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>770.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Erythroblastosis fetalis (hydropsia)</b> (c) <b>1 hr. 4 min</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>7 February, 19 58</b> , to <b>7 February, 19 58</b> , that I last saw the deceased alive on <b>7 February, 19 58</b> , and that death occurred at <b>10:05 A</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Russell Miller, Jr.</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>		DATE SIGNED <b>2-7-58</b>	
PHYSICIAN'S NAME (Type) <b>RUSSELL MILLER, JR. LT, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Arlington</b>		(State) <b>Virginia</b>		24a. REC'D BY REGISTRAR	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.D. Pumphrey</b>		ADDRESS <b>7531 Wisconsin Ave., Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Q. L. ...</b>	
DATE <b>FEB 10 58</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051389XV3

CERTIFICATE OF DEATH

REG. NO. 100

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

BUREAU V. 2

FEB 10 1959

RECEIVED

2119 CERTIFICATE OF DEATH

Reg. Dist. No. 02244

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>7 1/2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Harvey</u> Last <u>Vaughn</u>				4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 7, 1958</u>	
9. AGE (In years last birthday) yrs. <u>7 1/2</u>		IF UNDER 1 YEAR Months <u>7 1/2</u> Days <u>15</u> Hours <u>19</u> Min. <u>58</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Harvey Vaughn</u>		14. MOTHER'S MAIDEN NAME <u>Avenel Bright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Pt. s chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>773.5</u> DUE TO <u>Probable hyaline membrane disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable hyaline membrane disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Feb 7</u> , 19 <u>58</u> , to <u>Feb 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>58</u> , and that death occurred at <u>12:02 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Winston E. Cochran</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Winston E. Cochran, M.D. 927 Pershing Drive, Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hospital Takoma Park</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hax, Jr.</u> ADDRESS <u>Wash. San. &amp; Hospital</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Cochran</u>	

2175253XVI



BUREAU V. F.

MAR 6 1958

RECEIVED

2264 CERTIFICATE OF DEATH

Reg. Dist. No. 02245

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>27 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd's</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>/ ---</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Courtney</b> Middle <b>Anne</b> Last <b>Wade</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> , Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 7, 1890</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Allen H. Burdette</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Bosley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-34-9182</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant melanoma</b> <b>190.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <input type="checkbox"/> p. m. <input type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 24, 1958</b> , to <b>February 20, 1958</b> , that I last saw the deceased alive on <b>February 20, 1958</b> , and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Kurt W. Kohn</b>		M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>2/20/58</b>	
PHYSICIAN'S NAME (Type) <b>Kurt W. Kohn, M. D.</b>				<b>National Institutes of Health</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monacacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Grilton</b>				ADDRESS <b>Beallville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. ST.

1953 FEB 25

RECEIVED

2120

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
c. LENGTH OF STAY IN RURAL <u>24-56 days</u>				d. STREET ADDRESS <u>12217 Chabille Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Ambulatory and Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert</u> First		<u>Henry</u> Middle		<u>Walker</u> Last		4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-09</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Austin Walker</u>				14. MOTHER'S MAIDEN NAME <u>Blenche Hardister</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 2</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL INFARCTION</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>EMBOLIZATION RT CAROTID ARTERY (?)</u> DUE TO (c) <u>RHEUMATIC HEART DISEASE 10 YRS.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 10 1953</u> to <u>FEB 9 1958</u> , that I last saw the deceased alive on <u>2/8 1958</u> , and that death occurred at <u>3:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1352 UNIVERSITY LANE</u> DATE SIGNED <u>David Sterling</u>							
ACTUAL SIGNATURE <u>David Sterling</u> M.D.				PHYSICIAN'S NAME (Type) <u>HAROLD STERLING, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sheila Hines</u> ADDRESS <u>W.D.C. 2901 14th St. NW</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 13 58</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHIEF OF BUREAU		18. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		19. SIGNATURE OF DEPUTY CHIEF OF BUREAU		20. SIGNATURE OF SECRETARY	
21. SIGNATURE OF ASSISTANT SECRETARY		22. SIGNATURE OF CLERK		23. SIGNATURE OF CHIEF OF BUREAU		24. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		25. SIGNATURE OF DEPUTY CHIEF OF BUREAU	
26. SIGNATURE OF SECRETARY		27. SIGNATURE OF ASSISTANT SECRETARY		28. SIGNATURE OF CLERK		29. SIGNATURE OF CHIEF OF BUREAU		30. SIGNATURE OF ASSISTANT CHIEF OF BUREAU	
31. SIGNATURE OF DEPUTY CHIEF OF BUREAU		32. SIGNATURE OF SECRETARY		33. SIGNATURE OF ASSISTANT SECRETARY		34. SIGNATURE OF CLERK		35. SIGNATURE OF CHIEF OF BUREAU	
36. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		37. SIGNATURE OF DEPUTY CHIEF OF BUREAU		38. SIGNATURE OF SECRETARY		39. SIGNATURE OF ASSISTANT SECRETARY		40. SIGNATURE OF CLERK	
41. SIGNATURE OF CHIEF OF BUREAU		42. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		43. SIGNATURE OF DEPUTY CHIEF OF BUREAU		44. SIGNATURE OF SECRETARY		45. SIGNATURE OF ASSISTANT SECRETARY	
46. SIGNATURE OF CLERK		47. SIGNATURE OF CHIEF OF BUREAU		48. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		49. SIGNATURE OF DEPUTY CHIEF OF BUREAU		50. SIGNATURE OF SECRETARY	
51. SIGNATURE OF ASSISTANT SECRETARY		52. SIGNATURE OF CLERK		53. SIGNATURE OF CHIEF OF BUREAU		54. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		55. SIGNATURE OF DEPUTY CHIEF OF BUREAU	
56. SIGNATURE OF SECRETARY		57. SIGNATURE OF ASSISTANT SECRETARY		58. SIGNATURE OF CLERK		59. SIGNATURE OF CHIEF OF BUREAU		60. SIGNATURE OF ASSISTANT CHIEF OF BUREAU	
61. SIGNATURE OF DEPUTY CHIEF OF BUREAU		62. SIGNATURE OF SECRETARY		63. SIGNATURE OF ASSISTANT SECRETARY		64. SIGNATURE OF CLERK		65. SIGNATURE OF CHIEF OF BUREAU	
66. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		67. SIGNATURE OF DEPUTY CHIEF OF BUREAU		68. SIGNATURE OF SECRETARY		69. SIGNATURE OF ASSISTANT SECRETARY		70. SIGNATURE OF CLERK	
71. SIGNATURE OF CHIEF OF BUREAU		72. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		73. SIGNATURE OF DEPUTY CHIEF OF BUREAU		74. SIGNATURE OF SECRETARY		75. SIGNATURE OF ASSISTANT SECRETARY	
76. SIGNATURE OF CLERK		77. SIGNATURE OF CHIEF OF BUREAU		78. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		79. SIGNATURE OF DEPUTY CHIEF OF BUREAU		80. SIGNATURE OF SECRETARY	
81. SIGNATURE OF ASSISTANT SECRETARY		82. SIGNATURE OF CLERK		83. SIGNATURE OF CHIEF OF BUREAU		84. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		85. SIGNATURE OF DEPUTY CHIEF OF BUREAU	
86. SIGNATURE OF SECRETARY		87. SIGNATURE OF ASSISTANT SECRETARY		88. SIGNATURE OF CLERK		89. SIGNATURE OF CHIEF OF BUREAU		90. SIGNATURE OF ASSISTANT CHIEF OF BUREAU	
91. SIGNATURE OF DEPUTY CHIEF OF BUREAU		92. SIGNATURE OF SECRETARY		93. SIGNATURE OF ASSISTANT SECRETARY		94. SIGNATURE OF CLERK		95. SIGNATURE OF CHIEF OF BUREAU	
96. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		97. SIGNATURE OF DEPUTY CHIEF OF BUREAU		98. SIGNATURE OF SECRETARY		99. SIGNATURE OF ASSISTANT SECRETARY		100. SIGNATURE OF CLERK	

RECEIVED

FEB 15 1938

BUREAU V. S.



2463

## CERTIFICATE OF DEATH

02247

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>2216 Luzerne Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>E.</u> Last <u>Walls, Sr.</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April - 18 - 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Treasury Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>	
13. FATHER'S NAME <u>BERNARD WALLS</u>		14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXX Elizabeth Ebert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Bernard E. Walls Jr. (Same) Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> DUE TO (b) <u>Myocardial Infarction</u> <u>48 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary Artery Occlusion</u> <u>48 hrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old myocardial Infarction - Cerebral</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1949</u> , to <u>3 Feb</u> , 1958, that I last saw the deceased alive on <u>2 Feb</u> , 1958, and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merton L. White</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10134 Georgia Ave S.W. 3 Feb 58</u>	
PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR DATE <u>FEB 5 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shown, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1953 5 3

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02248

2461

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Maryland - Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. LENGTH OF STAY IN 1b <u>30 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> <u>56</u>		d. STREET ADDRESS <u>9216 Flower Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None - 9216 Flower Ave.</u>				d. STREET ADDRESS <u>9216 Flower Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mary Walker Walton</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Feb. 20, 1958</u> <u>19</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1879</u> <u>78</u> yrs.		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Brunswick, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Timothy W. Dexter</u>				14. MOTHER'S MAIDEN NAME <u>Ida Morton</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Isobel G. Dexter - Sister</u>		Address <u>9216 Flower Ave. Silver Sp. Md</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Parkinson's disease. 2. Anteriorly located heart disease</u>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Sept. 1948</u> , to <u>20 Feb. 1958</u> , that I last saw the deceased alive on <u>19 Feb. 1958</u> , and that death occurred at <u>11:40 A.M.</u> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)				DATE SIGNED				
ACTUAL SIGNATURE <u>Sevuch T. Kimble</u> M.D. <u>929 Peachtree Drive, Silver Spring, Md.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PHYSICIAN'S NAME (Type) <u>SEVUCH T. KIMBLE, M.D.</u>				<u>30 Feb. 58</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 26, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ch. of Our Savior</u>		22d. LOCATION (City, town, or county) (State) <u>Rio, Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons</u> ADDRESS <u>Washington, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 23 58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. OCCUPATION                  [Faint text]</p>	
<p>7. MARITAL STATUS                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. MEDICAL HISTORY                  [Faint text]</p>		<p>10. DATE OF DEATH                  [Faint text]</p>	
<p>11. PLACE OF DEATH                  [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [Faint text]</p>		<p>14. SIGNATURE OF WITNESS                  [Faint text]</p>	

BUREAU V. S.

FEB 25 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2465

## CERTIFICATE OF DEATH

02249

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 10 mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home for the Aged, Inc.</b>				d. STREET ADDRESS <b>3311 McElderry Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Christine</b> Last <b>WATSON</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>15</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 2, 1887</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>70</b>		IF UNDER 24 HRS. Days <b>15</b> Hours <b>19</b> Min. <b>58</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John F. Bishop</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Lighthouse</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-34-1413</b>		17. INFORMANT Address <b>Asbury Methodist Home, Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>auricular fibrillation</b> DUE TO (c) <b>cardiovascular disease + hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>obesity</b>							INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>off + on 1 yr</b> <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9-5</b> , 19 <b>56</b> , to <b>2-15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-12</b> , 19 <b>58</b> , and that death occurred at <b>8:35 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4208 P. Therry ST. Kensington, Md</b> DATE SIGNED <b>2-15-58</b>							
ACTUAL SIGNATURE <b>Sarah E. Glover</b>				M.D. <b>4208 P. Therry ST. Kensington, Md</b>			
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Inyermert</b>		22b. DATE THEREOF <b>2/18/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sam. J. Dickner &amp; Sons - Baltore</b> ADDRESS <b>hid</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2128 Items 8,9 Film 226 3-18-58 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Allegheny</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>one day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>811 E. Jefferson St.</b>		e. STREET ADDRESS <b>152 Ave. A., Forrest Hills</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas Raymond Watts</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/25/1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>20</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elec. engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ind.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas M. Watts</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Harris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b></b>		16. SOCIAL SECURITY NO. <b>169-09-6232</b>	
17. INFORMANT <b>Ray.D. Watts</b>		Address <b>Sames Item 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		DATE SIGNED <b>2/16/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/19/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Wilkesburg, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>7557 Wisconsin Ave. Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1880	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		HOME	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH	
FEB 20 1939		10:30 AM		HOME		NATURAL		HEART DISEASE	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		MANNER OF EXAMINATION		CAUSE OF EXAMINATION	
J. H. HARRIS		FEB 20 1939		HOME		NATURAL		HEART DISEASE	
SIGNATURE OF WITNESS		DATE OF WITNESS		PLACE OF WITNESS		MANNER OF WITNESS		CAUSE OF WITNESS	
J. H. HARRIS		FEB 20 1939		HOME		NATURAL		HEART DISEASE	

RECEIVED  
FEB 20 1939  
BUREAU V. 1

2466

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash 6 D.C.</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens, 3000 McComas Ave</u>		d. STREET ADDRESS <u>1812 K St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>A</u> Last <u>Whitman</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/23/68 ?</u>
9. AGE (In years last birthday) <u>89?</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerical</u>	
11. BIRTHPLACE (State or foreign country) <u>Erie, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Rest Home Records-3000 McComas Ave.</u>	
17. INFORMANT Address <u>Kensington, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>11 yrs</u> (c) <u>3 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9030 Fracture, left hip, Nov. 30, 1957, repaired same day Drs. Hosp Wash DC</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped on rug on way to front door to get morning paper</u>	
20c. TIME OF INJURY Month, Day, Year <u>10</u> Hour <u>11/30/57</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>1812 K St., N.W. Wash 6 DC</u> (County) (State)	
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>46</u> , to <u>Feb. 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 18</u> , 19 <u>58</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>1629 Columbia Road, NW Wash 9 DC</u>		DATE SIGNED <u>2/18/58</u>	
ACTUAL SIGNATURE <u>George Dewey</u> M.D.		PHYSICIAN'S NAME (Type) <u>George Dewey, M.D.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Erie Cemetery</u>		22d. LOCATION (City, town, or county) <u>Erie, Pennsylvania</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. H. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7-1-55

DATE OF DEATH FEBRUARY 24 1959		PLACE OF DEATH HOME	
TIME OF DEATH 10:00 AM		PLACE OF BIRTH BALTIMORE, MD	
SEX MALE		RACE WHITE	
AGE 68		OCCUPATION RETIRED	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
MEDICAL HISTORY HYPERTENSION		PREVIOUS ILLNESS NONE	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF DEATH REGISTRAR J. H. SMITH	
DATE OF SIGNATURE FEBRUARY 24 1959		DATE OF SIGNATURE FEBRUARY 24 1959	

BUREAU V. 3

FEB 24 1959

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2467

## CERTIFICATE OF DEATH

Reg. Dist. No.

02252

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington-Rural</b>				c. LENGTH OF STAY IN 1b <b>5 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Capital View Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frances Peole Williams</b>				4. DATE OF DEATH <b>FEB 8 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 2-1897</b>	
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poolesville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>Richard Peole</b>				14. MOTHER'S MAIDEN NAME <b>Florence Peole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>William Williams, 7007-Delaware St. Chevy Chase, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute heart failure</b> DUE TO <b>Branchio pneumonia</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>24 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 4 1958</b> to <b>Feb 7 1958</b> , that I last saw the deceased alive on <b>Feb 7 1958</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert J Thibadeau</b> M.D.				ADDRESS (Street, city or town, state) <b>10604 Concord St.</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT T. THIBADEAU</b>				DATE SIGNED <b>Feb 8-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 10-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Poolesville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>				ADDRESS <b>Poolesville, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Hedden</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
Richard Morris		1958-11-11		Home	
AGE		SEX		RACE	
68 years		Male		White	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
1890-01-01		Baltimore, Maryland		United States	
MARRIAGE		EDUCATION		OCCUPATION	
Married		High School		Retired	
MOTHER'S NAME		FATHER'S NAME		CAUSE OF DEATH	
Elizabeth Morris		John Morris		Heart Disease	
MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF PHYSICIAN	
Natural		11-11-58		[Signature]	
LOCALITY		COUNTY		STATE	
Baltimore		Baltimore		Maryland	

BUREAU A. B.

FEB 11 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2121

## CERTIFICATE OF DEATH

Reg. Dist. No.

02253

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>				d. STREET ADDRESS <u>12308 Duwey Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry John Wilson</u>				4. DATE OF DEATH Month Day Year <u>Feb. 19 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-22-92</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Joel A. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Maneri Laurena</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-03-1769</u>		17. INFORMANT <u>Chark</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>1952</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Generalized 7 mos.</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 10, 1958</u> , to <u>Feb. 19, 1958</u> , that I last saw the deceased alive on <u>Feb. 19, 1958</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7600 Carroll Ave. 2/19/58</u>							
ACTUAL SIGNATURE <u>Paul V. Starr</u> M.D.				PHYSICIAN'S NAME (Type) <u>Paul V. Starr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Kinsley</u>				24a. REC'D BY REGISTRAR <u>SILVER SPRING, MD</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Kinsley</u>	
				DATE <u>FEB 25 '58</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
JAMES EARL RAY		JAMES EARL RAY		FARMER		HOUSEWIFE		MOBILE, ALABAMA		MOBILE, ALABAMA	
EDUCATION		SCHOOLING		MARITAL STATUS		PREVIOUS MARRIAGES		DATE OF MARRIAGE		PLACE OF MARRIAGE	
HIGH SCHOOL		12		MARRIED		1		1950		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION	
4/4/68		MOBILE, ALABAMA		HEART DISEASE		NATURAL		4/4/68		MOBILE, ALABAMA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

OFFICE OF THE CORONER

RECEIVED  
FEB 25 1968  
BUREAU V. S.





CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	

**RECEIVED**  
FEB 20 1958  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2469

## CERTIFICATE OF DEATH

02255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>187 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>85x-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Coal City</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Blanche</b> Last <b>Withrow</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15,</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1895</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b>	IF UNDER 24 HRS. Days <b>62</b> Hours <b>62</b> Min. <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Gordon Gray</b>	
14. MOTHER'S MAIDEN NAME <b>Agnes Porter</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 144x DUE TO <b>Epidermoid carcinoma, hard palate. Extension to maxillae, nasopharynx, sphenoid and ethmoid bone.</b> 2 yr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Leptomeningitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x INTERVAL BETWEEN ONSET AND DEATH <b>2 yr.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 12, 1957</b> to <b>February 15, 1958</b> , that I last saw the deceased alive on <b>February 15, 1958</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 2/16/58</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>John R. Gill, Jr.</b>		M.D. <b>John R. Gill, Jr., M.D.</b>	
PHYSICIAN'S NAME (Type) <b>John R. Gill, Jr., M.D.</b>		22b. DATE THEREOF <b>2/17/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wildwood</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 20 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. E.

FEB 20 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2129

CERTIFICATE OF DEATH

Reg. Dist. No. 02256

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville 26</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 St. Philomena Rest Home Norbeck, Md</u>				d. STREET ADDRESS <u>4407-DANVERS ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Elizabeth O. Woolard</u>				4. DATE OF DEATH <u>Feb 8 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>William Sisson</u>				14. MOTHER'S MAIDEN NAME <u>ISABELLE Ashton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>519-28-0972</u>		17. INFORMANT <u>J.R. Woolard</u> Address <u>4407 DANVERS ST ROCKVILLE, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterial occlusion</u> <u>420.0</u> DUE TO <u>Cerebral arterial occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arterial occlusion</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2/6</u> , 19 <u>58</u> , to <u>2/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/6</u> , 19 <u>58</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. Weber</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CHARLES F. WEBER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladenburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> ADDRESS <u>4811 Gaiter rd</u>				24a. REC'D BY REGISTRAR <u>Feb 9 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

RECEIVED

FEB 19 1939

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02257

Reg. Dist. No.

2122

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 17		
c. LENGTH OF STAY IN 1b <u>7 Hrs-15 min</u>			d. STREET ADDRESS <u>6605 Gude Ave.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Jay</u> Middle <u>Ormond</u> Last <u>Wright</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-48</u>	9. AGE (In years last birthday) <u>9</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>Jay S. Wright II</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Huffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral contusion + hemorrhage</u> DUE TO (c) <u>fracture of skull</u> 7 1/2 hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>Rupture of spleen. Fracture of mandible (left) + femur at</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by car while sliding</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>2:45</u> P. M. <u>2-17</u> 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u> (County) <u>Takoma Park</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-18-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>		22d. LOCATION (City, town, or county) <u>Prince Georges County, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

FEB 30 1959

RECEIVED